

Hearing the voices of service users

See pages 5–7.

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Drugs policy in the new programme for government

As this newsletter goes to press, the government has not announced its intentions with regard to the future location of the Office of the Minister for Drugs and its functions. However, the new programme for government, *Government for National Recovery 2011–2016*,¹ contains a number of actions related to drugs policy. This article attempts to identify the implications of these actions should they be implemented.



Actions related to crime and justice

We will introduce roadside drug testing programmes to combat the problem of driving under the influence of drugs.

The development of reliable roadside testing procedure has been a challenging issue for many countries. At present the Garda Síochána, the Department of Transport and the Medical Bureau of Road Safety are collaborating in the development of a scheme to introduce US-style roadside tests on suspected drug drivers to accompany roadside alcohol tests.

We will ensure that violent offenders and other serious offenders serve appropriate prison sentences while at the same time switching away from prison sentences and towards less costly non-custodial options for non-violent and less serious offenders.

The first Bill introduced by the new Minister for Justice and Law Reform is the Criminal Justice (Community Service) (Amendment) (No. 2) Bill. This Bill creates an obligation on the courts, when sentencing an offender, to consider imposing a community service order in circumstances where a sentence of imprisonment of up to 12 months is being considered. Although the Bill does not mention specific offences, many offenders whose offences are committed as a consequence of drug addiction receive short custodial sentences and could benefit from the terms of this legislation.

A review will be conducted of the working of the mandatory sentencing laws in the context of an overall review of drugs policy.

The recent decision by the Supreme Court in DPP v Connolly raises a number of important issues in relation to the future application of s.15A and s.27 of the Misuse of Drugs Act 1977 (as amended).² These sections of the Act provide for a minimum presumptive sentence of ten years' imprisonment for possession of drugs with a market value of €13,000 or more. The Supreme Court quashed a previous conviction under s.15A on the basis that the burden of proof required to determine the purity and therefore value of the drugs had not been met by the prosecution.

We will strengthen the supply reduction effort and criminal assets seizures, particularly at local level. During the last Dáil, the Labour Party introduced the Proceeds of Crime (Amendment) Bill 2010. The purpose of the Bill was to reduce from seven years to two years the waiting period before the Criminal Assets Bureau can apply to the High Court for the disposal and forfeiture of assets frozen under s.3 of the Proceeds of Crime Act 1996. This Bill lapsed with the dissolution of the Dáil. The Labour Party's election manifesto, however, is committed to reintroducing this Bill, and to the strengthening of drug supply reduction efforts and criminal assets seizure at a local level.

We will carry out a full review of the Drug Treatment Court programme to evaluate its success and potential in dealing with young offenders identified as having serious problems with drugs.

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- Update on drug-related deaths and deaths among drug users
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Drugs policy in the new programme for government (*continued*)

We will end the practice of sending children to St Patrick's Institution.

The recent review of the Drug Treatment Court³ recommended that the programme be extended to offenders aged 16–18 years before the Children Court. The focus on young offenders may also be influenced by the commitment to end the practice of sending children to St Patrick's Institution.

Actions related to implementation of policy

Ensure every government department, agency or task force responsible for implementing elements of the National Addiction Strategy will be required to account to the Minister for their budget annually and to demonstrate progress on achieving targets. This measure aligns with Action 68 in the EU Drugs Action Plan 2009–2012, which calls on member states to 'develop and apply analytical instruments to better assess the effectiveness and impact of drug policy (e.g. model evaluation tools, policy effectiveness indices, public expenditure analysis, etc.)'.

In line with this action, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has developed a tool to assist member states in analysing their drug-related public expenditure. The EMCDDA distinguishes between two types of public expenditures – those explicitly labelled 'drug-related' and those which are not labelled as such and which are embedded in programmes with broader goals (e.g. the overall Garda Síochána budget). While labelled expenditures can be traced by exhaustively reviewing official financial reporting documents such as budgets and year-end reports, the EMCDDA advises that non-labelled expenditures have to be calculated through modelling/estimation approaches.

To date, Ireland has only reported on its labelled drug-related expenditures; it has not undertaken any modelling exercises to estimate the full amount of public expenditure on the illegal drugs issue.

Actions related to prevention and rehabilitation

Expand rehabilitation services at local level in line with need and subject to available resources.

Assist drug users in rehabilitation through participation in suitable local community employment schemes.

Work with local and regional drugs task forces to implement effective programmes aimed at preventing addiction in schools.

Require all local and regional drugs task forces to build on the success of Education Prevention Units in other task forces.

The four actions above are broadly in line with current drugs policy.

Develop compulsory as well as voluntary rehabilitation programmes.

If implemented, this action would represent a significant shift in policy. It is not clear how compulsory rehabilitation could be implemented in Ireland. The Welfare Reform Bill currently being debated in the UK parliament requires welfare claimants 'who are dependent on or have a propensity to misuse any drug' to follow a rehabilitation plan, and also contains powers to require welfare claimants to undergo drug testing.

Update the out-dated drugs awareness programmes in schools to reflect current attitudes and reality of recreational drug use amongst teens. This action appears to signal a shift away from the life-skills programmes in schools. There is evidence that these programmes are effective in improving decision-making skills and building resilience and resistance skills among young people. Alcohol, tobacco and cannabis are the main substances used by young school-going people. It is not yet clear how programmes can be developed to minimise the risks of such substance use among this population.

Actions related to treatment and harm reduction

Target resources to increasing the number of needle exchange programmes and rehabilitation places across the country where it is needed most. Action 34 of the NDS calls for the expansion of availability and access to needle exchange services as required. At the time of writing (March 2011), the nationwide needle exchange programme planned for 65 pharmacies (funded by a grant from the Elton John AIDS Foundation) has not been rolled out as the HSE and the Irish Pharmacy Union are still negotiating final terms.

Action 32 of the NDS calls for an integrated national treatment and rehabilitation service for all substance users. In 2007, the HSE Working Group on residential treatment and rehabilitation reported a shortfall of 104 inpatient detoxification places and 252.5 rehabilitation places.⁴

(Johnny Connolly, Brigid Pike, Martin Keane and Suzi Lyons)

1. Fine Gael and the Labour Party (2011) *Government for National Recovery 2011–2016*. www.taoiseach.gov.ie
2. Director of Public Prosecutions v Connolly. [2011] IESC 6. Supreme Court Record No. 478/2009. Date of delivery 15/02/2011. www.courts.ie/Judgments.nsf/Webpages/HomePage?OpenDocument&l=en
3. Department of Justice, Equality and Law Reform (2010) *Review of the Drug Treatment Court*. Dublin: Stationery Office. Available at www.justice.ie
4. Corrigan D and O'Gorman A (2007) *Report of the HSE Working Group on residential treatment and rehabilitation*. Dublin: Health Service Executive. www.drugsandalcohol.ie/6382

Where do drugs fit in?

In February 2011 Ireland elected a new government, which very quickly published its 'programme for government' for the next five years. It also immediately disbanded the Department of Community, Equality and Gaeltacht Affairs, in which the Office of the Minister for Drugs was located. At the time of going to press, however, the government had not announced its intentions with regard to the future location of the Office of the Minister for Drugs and its functions.

Drugnet Ireland looks back at how roles and responsibilities in relation to the drugs issue have been organised at national level since the first national policy document on the drugs problem in Ireland was published forty years ago.¹ Lead ministerial and departmental responsibility was assigned as follows.

1960s–early 1990s: The Minister for Health and his department initiated work leading to the 1971 *Report of the working party on drug abuse*, which recommended a series of initiatives to reduce the use of drugs and to help rehabilitate people who had acquired a drugs habit, and to the 1991 *Government strategy to prevent drug misuse*, which included a range of supply and demand reduction measures.

Mid 1990s: The Department of the Taoiseach became the centre of activity when the government established a Ministerial Task Force on Measures to Reduce Demand for Drugs under the chairmanship of the Minister of State to the Government, Pat Rabbitte TD. The two reports of this task force, published in 1996 and 1997, marked a turning point for Ireland's drugs policy, with the government recognising for the first time the link between problem drug use and socio-economic disadvantage and the need to involve local communities in tackling the problem.

1997–2002: The Department of Tourism, Sport and Recreation (DTSR) was given lead responsibility because it also had responsibility for local development and for co-ordinating a number of programmes promoting social inclusion, and was considered well placed to lead on the new strategic direction. A Minister of State within DTSR was given specific responsibility for implementing the recommendations in the two Ministerial Task Force reports.

The Steering Committee that drafted the *National drugs strategy 2001–2008* recommended that lead responsibility stay with the DTSR despite the fact that the Department of the Taoiseach or the Department of Health, because of either political authority or budget size, would have wielded considerable influence in furthering the drugs strategy. The Steering Group took the view that, as a service provider, the ability of the Department of Health to drive issues surrounding supply control and education and awareness issues would be limited, and that, conversely, the DTSR would be objective in relation to all the thematic areas covered by the national policy.

2002–2011: The newly established Department of Community, Rural and Gaeltacht Affairs (DCRGA) (changed in 2009 to Department of Community, Equality and Gaeltacht Affairs) took over local and community development responsibilities from the former DTSR and therefore also responsibility for co-ordinating the national drugs strategy. Between 2002 and 2007 a Minister of State within DCRGA was given special responsibility for the drugs strategy, and also for housing and urban renewal, which was administered by the then Department of the Environment

and Local Government; between 2007 and 2010, the Minister of State with responsibility for the drugs strategy was given responsibility for community affairs, administered by DCRGA, in lieu of housing and urban renewal. Following a Cabinet reshuffle in 2010, the drugs strategy was included in the responsibilities of the Minister for Community, Equality and Gaeltacht Affairs, Pat Carey TD, who had been Minister of State with responsibility for the drugs strategy and community affairs for 11 months in 2007/2008.

Over the years, three main groups of actors have been given responsibility for developing Ireland's drugs policy. To begin with, the need to include expertise seems to have been the guiding principle – the working party on drug abuse set up in 1968 comprised four civil servants, five representatives of statutory and local agencies, four independent professionals, one university academic and two university students. In 1983 and again in 1996, the need for political engagement was considered paramount: two task forces comprised entirely of ministers of state, for example, for health, education, justice, environment, foreign affairs, labour and social welfare, were set up to review the drugs problem and to make recommendations. The recommendations of the 1983 ministerial task force were never published although it is understood that, like the 1996/97 ministerial task force, it recognised the link between problem drug use and socio-economic disadvantage.²

Since the 1990s, government officials have gradually assumed a greater role in developing drug policy. In 1990 a Minister of State at the Department of Health chaired the committee, comprised entirely of senior civil servants, which drew up the 1991 *Government strategy to prevent drug misuse*. Subsequently, the 2001–2008 and 2009–2016 national drugs strategies were drawn up by 'groups' of senior departmental and state agency officials, together with a representative each of the voluntary and community sectors, which were chaired by a senior civil servant. These groups worked within terms of reference set by the government, consulted widely with experts and the public, and submitted their reports for approval by the government.

Since the mid 1990s, politicians have sought to maintain oversight by means of committees. In 1997 a Cabinet Committee on Social Inclusion and Drugs was established, chaired by the Taoiseach, and comprising government ministers with relevant responsibilities. In recent years the title of this committee has evolved into the Cabinet Committee on Social Inclusion, Children and Integration. The 2001–2008 National Drugs Strategy called for the establishment of a dedicated drugs sub-committee of the existing Oireachtas Committee on Tourism, Sport and Recreation, which would meet at least three times a year. This did not happen, and the Steering Group that reviewed the national drugs strategy in 2005 recommended that rather than set up a specific sub-committee, the Minister of State meet with the full Oireachtas Committee to discuss the Strategy and its implementation twice a year. This did happen.

The need for expert advice has always been acknowledged, starting with a call from the 1968–1971 Working Party on Drug Abuse for the establishment of a 'permanent advisory body'.² Currently the National Advisory Committee on Drugs (NACD) fulfils this function. Comprising representatives from academic disciplines, professional practitioners, civil and public servants, and representatives of the voluntary

Where do drugs fit in? (continued)

and community sectors, it advises the government, based on its analysis and interpretation of research findings. The 2009–2016 National Drugs Strategy called for the NACD to be brought within the ambit of the new Office of the Minister for Drugs (OMD): the intention was ‘to better address the issue of linkages between policy development and research’, while also seeking to maintain the ‘independence’ of the NACD.

The need for effective co-ordination was also first acknowledged by the 1968–1971 Working Party on Drug Abuse and it has proved an ongoing challenge.³ Most recently, the National Drugs Strategy 2009–2016 significantly simplified and streamlined the mechanisms put in place to help co-ordinate the work of the local and regional drugs task forces. The objective was to establish a clear hierarchy and a greater transparency of roles, from government and cabinet committee down to local project level. This was sought by establishing an Office of the Minister for Drugs (OMD) within the DCEGA, which would:

- absorb the work of both the former Drug Strategy Unit in the DCRGA and the National Drugs Strategy Team;
- introduce a ‘networked organisational’ structure, like that already operating in the Office of the Minister for Children, and thereby remove the need for the Interdepartmental Group on Drugs (IDG);

- bring the director of the NACD onto the management team of the OMD; and
- report directly to the Cabinet Committee on Social Inclusion, Children and Integration.

To support ‘integration’, the Steering Group proposed three additional mechanisms: an Oversight Forum on Drugs (OFD), an Advisory Group of the OMD, and the holding of twice-yearly bilateral meetings between the Minister for Drugs and various stakeholders. This number of mechanisms begs the question, is there a more efficient and effective means of engaging all stakeholders in the deliberation over and choice of policy options; for example, a single social partnership structure along the same lines as the National Economic and Social Forum (NESF) but focused on problematic substance use might perform such an integrating function.

(Brigid Pike)

1. The policy documents cited in this article are available on the website of the National Documentation Centre on Drug Use at www.drugsandalcohol.ie
2. For a full account, see Butler S (2002) *Alcohol, drugs and health promotion in modern Ireland*. Dublin: Institute of Public Administration, Chapters 5 and 6.
3. For a full account, see Pike B (2009) *Development of Ireland’s drug strategy 2000–2007*. HRB Overview Series 8. Dublin: Health Research Board, Chapter 4.

Retirement of Ms Mary Fanning

Staff working in the HSE Dublin North East addiction services recently bid a fond farewell to Mary Fanning, director of nursing, on her retirement. Mary joined the addiction services in 1998 as a clinical nurse manager and in 2000 became director of nursing for addiction services of the former Northern Area Health Board. During this time Mary was instrumental in the development of clinical nursing services within treatment centres and oversaw the development of many clinical nurse specialist roles. These included hepatitis C liaison, drug liaison midwifery and drug courts specialist nursing posts.

At a function held in City Clinic to mark the occasion, Dr Bríon Sweeney, medical director of the addiction services, paid personal tribute to Mary and acknowledged her contribution to the development of services over the years. These sentiments were echoed by colleagues both past and present.

We wish Mary a long and happy retirement and every success with any future pursuits she engages in.

(Vivion McGuire)

From research to policy: the Sax Institute seminar

In February 2011 the Department of Health and Children and the Health Research Board (HRB) organised a two-day workshop and a one-day seminar examining the Australian experience of evidence-informed policy and knowledge brokering. The events were facilitated and presented by Professor Sally Redman and Ms Deborah Frew from the Sax institute in New South Wales, Australia (www.saxinstitute.org.au).

Mr Jim Breslin, Department of Health and Children, and Mr Enda Connolly, Health Research Board, opened the seminar. Mr Breslin said that the seminar would provide strategies that would assist policy makers to direct and use research to inform policy and would enable researchers to complete research that was relevant to policy making. Mr Connolly reported that the HRB’s Strategic Business Plan 2010–14 will increase the Board’s investment in population health and health services research and facilitate the Department in locating and using this and other appropriate research.

From research to policy: the Sax Institute seminar (continued)

Dr Redman said that the Sax Institute wanted to create a two-way bridge between policy (makers) and research(ers). Her research in this area in 2003 found that policy makers wanted research that was timely, relevant, of high quality and easy to understand. In addition, policy makers wanted research that found specific, acceptable and appropriate evidence-based solutions to problems. Dr Redman identified three ways in which policy makers and researchers interact: the scientific approach (where researchers do and publish research and policy makers are responsible for locating and using it), the advocacy approach (where researchers do research and lobby for its use in policy) and the partnership approach (where policy makers and researchers decide the research needs together). There is not enough evidence to identify which, if any, approach is best.

The partnership approach appears to enhance exchange of knowledge between policy makers and researchers. Ms Frew reported that the Sax Institute uses Lomas's definition of knowledge brokering, which identifies the broker as an intermediary between research(er) and policy (maker).¹ The knowledge broker can be an institution or a person. The knowledge brokers at the Sax Institute are experienced both as researchers and as policy makers. The interventions that facilitate good knowledge brokering are structured process, strict parameters and feedback. A knowledge brokering session is most effective when the policy maker is clear about their needs, and the broker establishes a rapport with the policy maker, listens to their needs and clarifies research questions with them.

Ms Frew described the rationale for the Sax Institute Knowledge Transfer and Communications Programme. In 2003, the Institute found that 39% of policy makers believed that research was not relevant to policy; 87% said that



At the Sax Institute seminar: Professor Sally Redman, Mr Michael Scanlan, Ms Deborah Frew, Mr Enda Connolly and Mr Jim Breslin

research was not presented in a useful format; and only 5% had ever used research to inform policy. Seventy-two per cent of policy makers wanted brief research summaries. The Institute developed an evidence check process to facilitate a review of existing research and evidence tailored to the specific needs of the policy maker. Since 2003 the Institute has completed 90 evidence reviews on a wide variety of topics. Each review takes approximately eight weeks to complete. The Institute follows up on the use of evidence reviews three months after they are completed to determine satisfaction with the process and how the review is used.

The Department of Health and Children has asked the HRB to complete a number of evidence reviews by September 2011 using the evidence check process.

(Jean Long)

1. Lomas J (2007) The in-between world of knowledge brokering. *British Medical Journal*, 334(7585): 129–132.

Involving service users: the Irish experience

Action 42 of the National Drugs Strategy 2009–2016 identifies the need to further involve the users of drug treatment services, 'both as an essential part of clinical governance procedures and service planning' (para. 4.79). The issues to be considered when involving service users are highlighted in a recent qualitative study of service user involvement in a Dublin-based methadone maintenance service.¹

Completed in mid-2008, this study was based on in-depth semi-structured interviews with eight providers from the service, three drugs task force co-ordinators and the co-ordinator of the drug-user group, and eight service users attending different clinics across the broad geographical area in which the service operated. The author, Aoibhinn King, of the School of Social Work and Social Policy, Trinity College, Dublin, identified issues around five themes:

1. **Purpose of the service:** There were conflicting views about the purpose. Service users were clear that the purpose was to contribute to a reduction in the difficulties they experienced through drug use and to the stabilisation and normalisation of their lives. Service providers were more ambivalent: while many saw abstinence as the final goal, they claimed that harm reduction and improved quality of life were the actual outcomes.
2. **Understanding of user involvement:** While there was overall consensus that user involvement was both progressive and desirable, and increased the effectiveness of the service, in reality, service users' experience was that the system did not engage with them: 'I'm not involved at all, like they haven't asked me to do anything, just come up and get me methadone.'
3. **Determining own care:** Respondents generally endorsed the principle that service users have valuable knowledge and experience that can help in planning and delivering their care programme, but they were almost unanimous in stating that, in practice, service users played little or no part in determining their own treatment. Moreover, there was a prevailing view that both service users and service providers gave higher priority to issues around methadone maintenance than to addressing the issues which impacted on the individual's life and influenced their drug use.
4. **Involvement in service evaluation, planning and development:** Involvement was perceived as largely symbolic. Several obstacles were identified, including resource constraints, organisational and national protocols and procedures, unrealistic expectations on the part of service users, disillusionment and fear of criticism on the part of service providers. The author also noted, 'the culture within services served as the most significant barrier to meaningful collaboration'.

Involving service users *(continued)*

5. **Operational system and interactions between service users and service providers:** The author found that the staff attitudes common under the 'old system' of treatment still pervaded the culture in treatment services and was the main impediment to the active engagement of service users. Staff tended to define service users in negative stereotypical terms, and service users, in turn, characterised their relationship with treatment systems primarily in terms of fear, rather than terms of equality or mutuality.

King described the explicit acknowledgement of the imbalance of knowledge and power between provider and user as 'remarkably stark'. While the service studied was nominally imbued with the harm reduction ethos, the author found that the underlying philosophy of the old drug treatment system had not shifted to any great extent.

To bring the treatment service into line with harm reduction philosophy, King concluded that much more was needed than simply including abstract statements of principle in official policy documents: 'It may be that what is needed is a more explicit and committed approach which incorporates the education and training of all involved in the delivery of treatment services for illicit drug users, if the situation identified here is not to persist'.

(Brigid Pike)

1. King A (2011) Service user involvement in methadone maintenance programmes: the 'philosophy, the ideal and the reality'. *Drugs: education, prevention and policy*. [Early online PDF, 7 Sep 2010]. <http://informahealthcare.com/toc/dep/0/0>

Organising drug users: insights from Britain

In a recent study of health and society in Britain since the 1960s,¹ the purpose of which was to explore the changing pattern of relationships between the state and civil society, authors Alex Mold and Virginia Berridge describe how groups representing drug users have emerged in the last decade in response to 'state-directed user involvement', such as that described in the preceding article on the involvement of service users in a Dublin methadone programme. Mold and Berridge identify three categories of user groups in Britain – service users, activist users, and carers (principally parents and families of users).

With regard to the first category, the authors outline how service users started to form groups as the state began taking a greater interest in the views of users. They found there were limits to how far the state was prepared to listen to the views of users: they use the term 'tokenism' to describe the nature of the engagement. A separate study of the role of service user groups in a sample of drug action teams (DATs) in England² found that these groups were experiencing problems with long-term sustainability, owing to short-comings in their governance arrangements. The researchers concluded, '...groups established within an agency for the purpose of user involvement (UI) must have adequate resources to meet a well-defined objective. Management processes, leadership and lines of communication must be clear. User self-organizations ought to be invited and enabled to contribute to UI in a manner that promotes sustainability of the group and meets clearly defined objectives without compromising their self-defined purpose. The power imbalance that is inherent in UI in the drugs-treatment field must be explicitly addressed' (p. 96).

Mold and Berridge describe how, in parallel to the emergence of service user groups, drug users in Britain also began to organise in activist user groups. While interested in issues of service provision, these groups are also interested in broader social and political issues such as identity, rights, empowerment and drug policy. These groups have encountered difficulties including inability to access funding and the inability of a disparate membership to agree common positions.

The authors note that, at the international level, drug users have also become more vocal, participating in drug policy conferences and lobbying international policy bodies. Examples include the International Network of People who Use Drugs (INPUD), which is supported by the International Harm Reduction Association (IHRA), and the European Network for Just and Effective Drug Policies (ENCOD),³ which lobbies the institutions of the European Union, and the United Nations Commission on Narcotic Drugs (CND). However, such groups experience greater difficulties than other NGO groupings in obtaining accreditation.

Looking to the future, the authors suggest that the way in which citizens who also use drugs will contribute to the ongoing debate on policy in relation to psychoactive drugs will depend to a great extent on the direction that drug policy takes. They identify two opposing trends in Britain's drug policy: one moving in favour of abstinence and a tougher stance on drug use, and one moving towards liberalisation and the establishment of drug use as a human 'right'. The authors see the recent push towards abstinence as undermining the position of activist users who have sought to reclaim drug use as a legitimate practice and identity, while more coercion in drug treatment is seen as running counter to efforts to win greater choice and more rights for patients.

The authors conclude, 'It is impossible to say which direction drug policy will move in, but it is certain that voluntary organisations, however reconstituted and reconfigured, will play a key part in whatever is to come' (p. 178).

(Brigid Pike)

1. Mold A and Berridge V (2010) *Voluntary action and illegal drugs: health and society in Britain since the 1960s*. Basingstoke, Hants: Palgrave Macmillan.
2. Patterson S, Weaver T and Crawford M (2010) Drug service user groups: only a partial solution to the problem of developing user involvement. *Drugs: education, prevention and policy*, 17(1): 84–97.
3. For more information on these international activist user organisations, visit www.inpud.net and www.encoded.org

'Building a service user voice' – an interactive workshop

On 14 January 2011 Tallaght Drugs Task Force hosted an interactive workshop, 'Building a service user voice', in co-operation with the Tallaght Service Users Forum. The Forum was established in 2005 with three goals: to be an effective strategic and professional committee/forum; to engage, inform and hear the voice of service users; and to support the partnership of service users and service providers to enhance service design and delivery.

During the workshop, participants got the opportunity to work in groups with members of the Forum and service providers as well as representatives from the voluntary and statutory bodies. Each of the working groups explored barriers to service-user participation and what could be done to overcome them.

The Forum has set as additional goals for 2011:

- advertise the forum and its work;
- maintain good communication with service providers;
- run courses and workshops for service users;
- organise outreach projects;
- meet service users and support them;
- provide information on how to access treatment services.

Further information on the Service Users Forum and other services offered by Tallaght Drugs Task Force can be accessed on the Task Force website www.tallaghtdtf.ie.

(Vivion McGuire)

Drugnet digest

This section contains short summaries of recent reports and other developments of interest.

ISPCD survey of young people's alcohol use

In December 2010 the Irish Society for the Prevention of Cruelty to Children (ISPCD) published the results of a survey they conducted among 9,746 young people aged 12–18 years in 2009.¹ This survey examined young people's alcohol use, their attitudes towards teen and parental alcohol use and the effects of parental alcohol use on their lives, and included young people from 84 educational institutions (70 secondary schools, eight primary schools and six Youthreach centres) across Ireland.

Over two fifths (45%) reported that they drink alcohol and 25% reported they had engaged in binge drinking in the two weeks prior to the survey. As the data in the report are not presented by age it is not possible to compare drinking trends between younger and older respondents.

The survey also questioned young people on their attitudes and beliefs about their own alcohol use and about their parents' drinking; 56% stated that they did not believe it was 'okay' for teenagers to drink alcohol to get drunk and 79% disagreed with parents drinking alcohol and becoming drunk in front of their children.

One in ten stated that their parent/guardian's alcohol use affected their life. The effects of parental drinking described by the respondents included emotional impacts, abuse and violence, impacts on family relationships and changes in parental behaviour.

Filling a gap at BAAG

Bluebell Addiction Advisory Group (BAAG) was founded in 2004. The organisation provides programmes such as the Get Active Group (GAP) for women and the Men's Gardening Group. GAP aims to fill the gaps left by addiction, such as boredom, isolation and depression, through a programme of activities designed to tap into hidden talents and build on existing interests.

GAP members took part in a six-week cookery course with chef Yves Tastet and produced a cookbook that focused on nutrition and healthy eating as a way of avoiding health problems such as depression, low energy levels and liver disease. The cookbook, *Filling a gap at BAAG*,² was launched by the Canal Communities Local Drugs Task Force in 2010.

Members of the group have visited other task force projects and recreated dishes from the cookbook in an effort to motivate others to make nutrition and health a priority in their recovery. A catering service run by GAP has catered for up to 100 people at events organised by Dublin City Council, Canal Communities Local Drugs Task Force, Rialto Youth Project and the Community Lynks Project.

GAP works in partnership with the Men's Gardening Group to create jobs within the local community. The men's group grows fruit and vegetables which are bought by GAP for their catering business. The groups recently worked together to acquire skills in producing Christmas wreaths and table centre pieces. The groups are currently working together planting fruit trees and will produce jam for community sales in the future.

The group has taken ownership of its activities; members carry out duties and roles, including those of cookbook tour co-ordinator, leaflet and business card design and donations manager. GAP provides summer camps and events for members' children so that the women can continue in their programme during school holiday periods.

(Contributors: Deirdre Mongan and Anne Marie Carew)

1. Irish Society for the Prevention of Cruelty to Children (2010) *If they're getting loaded why can't I?* Dublin: ISPCD. www.drugsandalcohol.ie/14344
2. Get Active Group (2010) *Filling a gap at BAAG*. Dublin: Bluebell Addiction Advisory Group.

Twelfth annual Service of Commemoration and Hope

On Tuesday 1 February, the Family Support Network held its twelfth annual Service of Commemoration and Hope, entitled ‘Reclaiming Family Through Rehabilitation’, in remembrance of loved ones lost to drugs and related causes and to publicly support families living with the devastation that drug use causes.

The service in Our Lady of Lourdes Church, Sean McDermott Street, was attended by President Mary McAleese, Mr Pat Carey TD, Minister of State, Commander Mick Treacy, aide de camp to the Taoiseach, and Bishop Eamon Walsh and other religious representatives, as well as family members, friends and representatives from family support groups throughout the island of Ireland and in Scotland, and many people working in this area.

Sadie Grace of the Family Support Network highlighted the important role families play in the rehabilitation process, and the need for rehabilitation services to recognise that families also require help and support. She said it was important for the next government to prioritise the drug issue and the value of family support.

Minister Carey, in an emotional speech, stated that the Family Support Network is a vital part of the National Drugs Strategy, and emphasised the importance of the single strategy on alcohol and substance misuse being delivered as soon as possible.

President McAleese recited the poem ‘For Lost Friends’ by John O’Donohue. Bishop Walsh, Fr Edmond Grace and Ruaidhri McAuliffe, representing the drug users’ forum UISCE, also addressed the gathering.



President Mary McAleese speaking at the service

For many families, this service is the first time that they can openly grieve for their loved ones lost to drug use and related causes. Personal testimonies were given by members of family support groups, reflecting the support received through these groups. Music was provided by the Gardiner Street Gospel Choir.

(Ena Lynn)

Contact the Family Support Network at 16 Talbot Street, Dublin 1. Tel: 01 836 51 68; email: info@fsn.ie; web: www.fsn.ie

Correction to article in *Drugnet Ireland* 36 (Winter 2010)

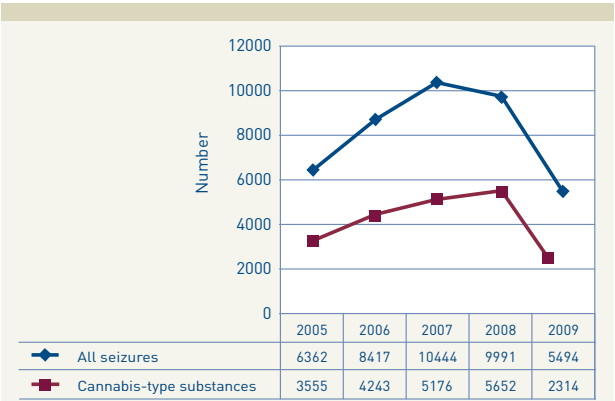


Figure 3 Trends in the total number of drug seizures and cannabis seizures, 2005–2009

Source: Compiled by the Forensic Science Laboratory drug section and reported by the Central Statistics Office

Figure 3 (p. 24) in the article ‘Drug-related crime statistics’ was incorrectly labelled owing to a production error. The correctly labelled figure is shown opposite.

Health and homelessness: the Simon snapshot study

The Simon Communities of Ireland published a report on health and homelessness in late 2010.¹ This report presents the findings of a 'point in time' survey undertaken between 26 July and 1 August 2010 at all eight Simon Communities in Ireland. The survey collected data on the profile and health needs of people using Simon projects and services over a one-week period.

Methods of data collection

Data for the 788 questionnaires were collected in face-to-face interviews and in a review of the records of the individuals using the projects and services during the one-week period. The survey respondents were selected through convenience sampling, which is a sample of the population selected because it is close at hand and readily available. Sampling of this nature can provide useful insights into the health needs of a proportion of the people using Simon services but the data generated from such a sample cannot be generalised to the health needs of the wider homeless population. Data were collected from three types of service users:

- those who were currently homeless;
- those who had been homeless and needed support to maintain their current home;
- those who were at risk of becoming homeless.

Profile of the sample

78% were male.

85% were Irish, 6% were British, 5% were Eastern European and 1.4% were Irish Travellers.

9% were aged between 18 and 25, 21% were aged between 26 and 35 and 54% were aged between 36 and 55.

51% received a disability allowance and 6% received the old age pension.

6.5% were classified as not being habitual residents.

65% were registered as homeless with the local authority.

Duration of homeless experience

Of the 471 people presently homeless; 20% were homeless for six months or less, 45% for between seven months and five years, and 35% for more than five years.

Of the 146 people who were formerly homeless and who were now being supported by Simon Tenancy Sustainment services, 58% reported being homeless for more than three years.

Thirty-five per cent (277) were currently living in vulnerable situations, such as rough sleeping, emergency accommodation, squats and bed and breakfasts.

Fifty-seven per cent (449) were currently living in accommodation with some level of support; this included high-support housing, low-support housing, local authority accommodation with support, the private rented sector with support and transitional accommodation. Only 6% were living independently with no support.

Reasons for first becoming homeless

When responses on primary and secondary reasons for becoming homeless in the first instance were combined and analysed together, the main reasons given were personal alcohol use (19%), family conflict (14%), personal drug use (12%) relationship breakdown (9%) and personal mental health problems (7%).

Physical health conditions

Fifty-six per cent (442) of the respondents had at least one diagnosed physical health condition. The most common of these were:

- 123 cases of cardiovascular disease, including angina, hypertension and stroke;
- 115 cases of infectious disease, including (most commonly) hepatitis C, and also hepatitis B, HIV, sexually transmitted infection, tuberculosis and urinary tract infection;
- 88 cases of injury, including head injury, broken bones and cuts;
- 74 cases of respiratory disease, including asthma, chronic obstructive pulmonary disease, pneumonia and pleurisy;
- 45 cases of neurological disorder, including epilepsy. Parkinson's disease, motor neuron disease, spinal muscular atrophy and muscular dystrophy.

Thirty-six per cent of respondents reported one or more undiagnosed physical health problem.

The report points out that this data may suggest 'that the experience of homelessness has a significant negative impact on the physical health of people and that their health status significantly deteriorated since the start of their homelessness experience'.

Diagnosed mental health conditions

Fifty-two per cent (411) of the respondents had at least one diagnosed mental health condition; 29% reported having depression, 9% schizophrenia, 7% panic attacks, 5% social anxiety disorder, 4% mild cognitive impairment and 3% bi-polar disorder.

Forty-four per cent of respondents reported one or more undiagnosed mental health conditions.

Alcohol and drug use

Of the 769 people who answered the question, 66% reported consuming alcohol. Fifty-five per cent of respondents had physical complications as a result of alcohol use. Of the 768 responses, 38% reported using drugs other than alcohol. Heroin was the most common other drug used, followed by cannabis (Table 1 overleaf). Thirty-one per cent of respondents who used drugs were using two drugs at the same time and 25% were using three drugs. Fifteen per cent (115) of all respondents were intravenous (IV) drug users. Seventy-eight respondents were tested for blood borne viruses.

Health and homelessness (continued)

Table 1 Drugs most commonly used by survey respondents (n=768)

| | n | % |
|--|-----|------|
| Heroin | 159 | 20.7 |
| Cannabis | 116 | 15.1 |
| Benzodiazepines (prescription status not reported) | 94 | 12.2 |
| Head shop substances | 54 | 7.0 |
| Methadone (unprescribed) | 53 | 6.9 |
| Cocaine | 17 | 2.2 |
| Other | 24 | 3.1 |
| Unknown | 13 | 1.7 |

Complex needs

The report outlines the presence of a range of complex needs among the service users who participated in the research. For example, 28% had at least one diagnosed physical and at least one diagnosed mental health condition, and 28% were diagnosed with a mental health condition and reported complications arising from alcohol and/or drug use.

Challenging behaviour

The majority (65%) of homeless people do not present with challenging behaviour (such as withdrawn aggressive or violent behaviour).

Suicide and self-harm

Fifteen per cent of respondents reported self-harming episodes at the time of the survey, 23% reported suicide ideation and 8% had attempted to commit suicide in the six months prior to the survey.

Service use

The overwhelming majority of survey participants (84%) were medical card holders and 91% were registered with a general practitioner. Sixteen per cent of respondents who answered the question had attended accident and

emergency services in the last month, 20% had attended an out-patient hospital department and 8% had been admitted to hospital.

Comparisons with other studies

More men, older people and people from outside Ireland, and a higher proportion of people on disability allowance, attend Simon Community services than observed in studies of other homeless services.²⁻⁴ The proportion registered as homeless was similar to that in the NACD study.³ The reasons given for becoming homeless were the same across the comparison studies, but the proportion reporting each reason was different, reflecting age and gender differences between study groups. The proportion with diagnosed physical and mental health conditions was lower in the Simon study than in comparison studies, possibly because the Simon study included users of a broad range of services (including supported housing), while other studies tended to include users of emergency accommodation. The proportion reporting alcohol use was similar to that in other Irish studies. The drug use data in the Simon study did not allow for comparison with that in other studies.

(Martin Keane and Jean Long)

1. Simon Communities of Ireland (2010) *Health and homelessness: health snapshot study of people using Simon services and projects in Ireland*. Dublin: Simon Communities of Ireland. www.drugsandalcohol.ie/14750
2. Homeless Agency (2008) *Counted in, 2008: a report on the extent of homelessness in Dublin*. Homeless Agency Partnership, Dublin. www.drugsandalcohol.ie/11718
3. Lawless M and Corr C (2005) *Drug use among the homeless in Ireland: a report for the National Advisory Committee on Drugs*. Dublin: Stationery Office. www.drugsandalcohol.ie/5950
4. O'Carroll A and O'Reilly F (2008) Health of the homeless in Dublin: has anything changed in the context of Ireland's economic boom? *European Journal of Public Health*, 18(5): 448-453. www.drugsandalcohol.ie/12519

Housing people who misuse substances

The St Dominic's Housing Association (SDHA) recently commissioned research to examine the applicability of the Housing First model to people with substance misuse issues, and to identify best practice in relation to supports needed to ensure tenancy sustainment for this vulnerable group. The resulting work was undertaken by independent consultant Simon Brooke and a report was published by the SDHA in January 2011.¹

The work included reviewing a selection of studies, and consultations with nine organisations and twelve service users. Chapter one of the final report details the emergence of the Housing First approach in the US, and examines the evidence base for its effectiveness in comparison to traditional approaches. The defining feature of the Housing First approach is its focus on assisting homeless people to move into permanent accommodation and providing appropriate support services to sustain them in their

tenancy. In contrast to traditional approaches, the Housing First approach does not require people to be abstinent from substance use prior to securing accommodation.

The report cites a number of evaluations of the Housing First approach, most of which were done in the US. The evidence suggests that individuals participating in Housing First programmes spend less time homeless and in psychiatric hospitals and incur fewer costs to the health system than those availing of the traditional approach. The report cites a recent review which suggests that the evidence on Housing First for individuals with severe substance addiction is inconclusive.² This is in part explained by the lack of studies comparing the Housing First approach with an alternative approach for individuals recruited on the basis of having a severe addiction to substances. As Brooke points out in the SDHA report, the inconclusive nature of the evidence does not suggest that the Housing First approach will not work

Housing people who misuse substances (continued)

for people who misuse substances, but that more rigorous research is required to test its effectiveness with people with severe substance addictions. Nonetheless, the report does concur with the general consensus emerging from the literature that stable accommodation is an important factor in encouraging people to engage with treatment services and in achieving stability and abstinence.

Practical issues to consider when housing people who misuse substances

The report outlines a number of practical issues that need to be considered when placing people with substance addictions in permanent housing. These issues were raised during consultations with stakeholders and were identified in a number of reports from the UK which address this topic.

Before moving in

The report outlines a number of issues that need to be considered before potential tenants move into their new home, such as choice of location, the challenge of avoiding unwanted guests, and sensitivity to perceptions of neighbours.

The role of the landlord

There needs to be a clear understanding of the role of landlord and the visiting support team and good lines of communication between the two. This approach can ensure that any emerging issues around rent arrears or anti-social behaviour can be dealt with in a timely and professional manner.

Housing-related supports

According to the author, in Ireland the housing-related supports for Housing First tenants will be provided by the Support to Live Independently (SLI) scheme delivered by Dublin Simon Community.

Isolation and loneliness

Loneliness and isolation were identified as major problems experienced by people who misuse substances. According to Brooke, these people, who are mainly young single men, may find themselves living in an unfamiliar area, perhaps living alone for the first time, and at the same time cut off by choice from previous friends.

The report highlights ongoing work in the UK on developing befriending and mentoring schemes as possible ways to reduce the isolation and loneliness experienced by this group when they move into stable accommodation.

Meaningful activity during the day

Interviews with stakeholders revealed the importance of meaningful activity during the day for service users who are housed. Participation in Community Employment programmes and pursuing educational and recreational activities were mentioned by service users as appropriate activities; they also talked about the onset of boredom and potential relapse when their day lacked meaningful activity.

Family and social contacts

The importance of family and social contacts were mentioned by stakeholders; equally, it was said that, in some cases, family contact would not be a realistic option in the medium or long term.

Who is Housing First not appropriate for?

The report contains a number of extracts from interviews with individual substance misusers. The general theme running through these accounts is that not all substance users will benefit from the Housing First approach. Interviewees spoke about the difficulties involved in managing the responsibility of paying bills and running a home while actively using drugs. They recalled both personal and anecdotal experiences of returning to the hostel or the street when the responsibility of maintaining their tenancy became compromised by substance use. A number of interviewees spoke about the problems of maintaining their tenancy while on crack cocaine. These accounts illustrate the need for effective floating support when people who misuse substances are placed in Housing First programmes. They require support with budgeting, cooking and other domestic chores and encouragement to engage with treatment.

Conclusion

Brooke concludes by saying,

Although Housing First is largely untested in Ireland, and ... the specific case of people with substance misuse problems is less well researched than other groups, there is widespread belief among stakeholders in Ireland ... that provided it is done properly, the Housing First approach can be successful for people with substance misuse problems. (p. 20)

Ultimately, the approach requires a supply of affordable housing to be made available to house homeless people. To this end, and as outlined in this report, the Department of the Environment, Heritage and Local Government has established the Social Housing Leasing Initiative to release the large amount of empty properties for social housing. However, according to this report, 'regrettably ... very little social housing has been produced by this scheme, which means that the Housing First approach is currently stalled'.

(Martin Keane)

1. Brooke S (2011) *Housing people who misuse substances: making Housing First work*. Dublin: St Dominic's Housing Association. www.drugsandalcohol.ie/14838
2. Kertesz SG, Crouch K, Milby JB, Cusimano RE and Schumacher JE (2009) Housing First for homeless persons with active addictions. Are we overreaching? *The Millbank Quarterly*, 87(2): 495–534.

HSE plan for drug-related services in 2011

The HSE National Service Plan 2011 sets out the agency's plan in the drugs and alcohol area for 2011.¹ A priority for the HSE Social Inclusion Services, which include addiction services, is to 'continue to address the health impacts of addiction and/or substance misuse'. The Social Inclusion Services have also prioritised actions to enhance the health

and well-being of other vulnerable groups, including the homeless, Travellers, ethnic minorities and members of the lesbian, gay, bisexual and transgender (LGBT) communities.

'Deliverable outputs' for 2011 are listed in the following table.

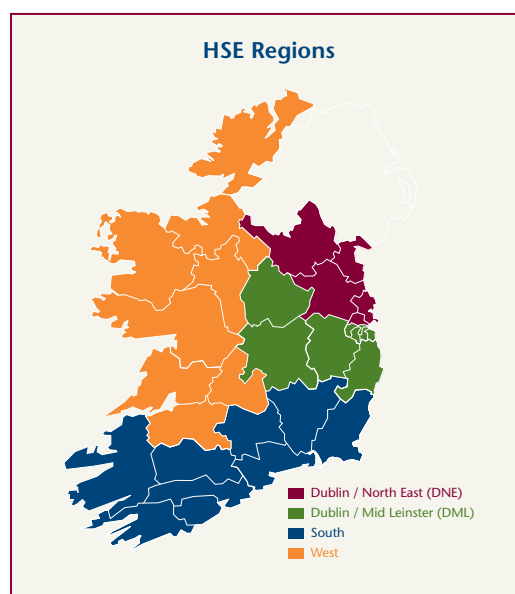
| Key result area | Deliverable outputs 2011 | Target completion |
|---|--|-------------------|
| National Drugs Strategy (NDS) 2009–2016 | Recruitment of clinical directors of addiction services completed in each of the four regions | Q3 |
| | Implementation of Phase 1 of interagency rehabilitation programmes in each of the four regions | Q3 |
| | Learning from reports implemented, including hepatitis C and intravenous drug users and methadone protocol | Q3 |
| | Pharmacy-located harm reduction/needle exchange services implemented throughout the country in each of the four regions | Q3 |
| | Alcohol public education/awareness campaign developed and launched | Q2 |
| | Screening and brief interventions available in emergency departments and primary care services (Phase 1) | Q4 |
| | National Addiction Training framework in place for staff (Phase 1) | Q3 |
| National Homelessness Strategy | Protocols signposting referral pathways developed between specialist addiction/homeless/Traveller services and mental health and primary care services | Q4 |
| All-Ireland Traveller Health Study | Screening programmes targeting vulnerable groups [among the Traveller population] devised and implemented | Q4 |
| National Intercultural Health Strategy | Emergency multi-lingual aid toolkits for staff and intercultural health guide implemented | Q3 |
| | Translation/interpreting toolkit for staff in line with Patient Charter implemented | Q2 |
| LGBT Framework | Good practice guiding principles developed to support LGBT communities in equitable access and use of health services | Q4 |

Source: HSE National Service Plan 2011, pp. 49–50

With regard to drug treatment, comparison with the 2010 plan indicates that the HSE is seeking to maintain similar overall levels of activity and performance in 2011 while increasing service provision in the South and West regions.² No explanation for the changes in the levels of treatment supply and demand across the HSE regions is given in the plan.

Methadone treatment – The target for 2011 is to increase the total number of clients in methadone treatment outside prisons by 2.6%, from 8,278 to 8,500, and the number in treatment in prisons by three, from 497 to 500. While the number of clients in methadone treatment in the DML and DNE regions will rise by 1% (from 7,861 to 7,950), in the South Region the number is set to increase by 47% (from 187 to 275), and in the West Region by 19.6% (from 230 to 275).

Treatment of substance misusers over 18 years following assessment – In 2011 the total number of substance misusers over 18 years who will have commenced treatment following assessment is set to decline by 2%, from 1,380 to 1,350. In the DML and DNE regions the number will decline by 67% (from 870 to 520), while in the South and West regions it will increase by 63% (from 510 to 830).



HSE plan for drug-related services in 2011 *(continued)*

In 2010 the target of ensuring that 100% of substance misusers over 18 years started treatment within one calendar month of assessment was not achieved: in the DML and DNE regions only 70.6% and 71.1% respectively entered treatment within the month, while in the South and West regions the proportions were 98.5% and 97.7% respectively. In 2011 the HSE will again try to reach the 100% target.

Treatment of substance misusers under 18 years following assessment – In 2010 the total number of substance misusers under 18 years who commenced treatment following assessment exceeded the target of 115 by 18% (n=136). While the DML, DNE and South regions all came in on or under target, the West Region exceeded its target by 46% (65/30).

The 2010 target of ensuring that 100% of substance misusers under 18 years commenced treatment within two weeks of assessment was met in the DML and DNE regions, but was not achieved in the South and West regions. In 2011 the HSE has again set the target at 100% for all four HSE regions.

Children and families

The 2011 plan sets out the HSE's priorities and actions with regard to delivering its statutory services in the areas of children in care, after care and youth homelessness, and also with regard to maintaining and developing family support services and strengthening the provision of aftercare services.

Specifically in relation to substance abuse, the service plan states that an 'analysis of addiction services for children

nationwide based on best practice' will be completed in the fourth quarter of 2011. This action is in response to Recommendation 3 in the Report of the Commission to Inquire into Child Abuse (the Ryan Report), on the provision of counselling and educational services for children, which called on the HSE and the drugs task forces to establish addiction services for children nationwide based on best practice by June 2011.

Mental health

In the mental health area the HSE's priorities in 2011 are to:

- continue to implement elements of *A vision for change*, particularly reconfiguration of services from a model of care predicated on inpatient provision to a community-based recovery model, reconfiguration of community mental health teams, development of clinical pathways and progressing the capital infrastructure,
- implement measures to reduce suicide rates, and
- enhance the provision of child and adolescent mental health services.

(Brigid Pike)

1. Health Service Executive (2011) *National Service Plan 2011*. Available at www.hse.ie
2. For an overview of the 2010 objectives, see Pike B (2010) HSE aims to strengthen drug services delivery. *Drugnet Ireland*, (34): 8–9.

Working together for better quality in drugs services

To help ensure drug treatment and rehabilitation outcomes are achieved and to maintain a high standard of client safety, the National Drugs Strategy 2009–2016 calls for the introduction of 'a clinical and organisational governance framework for all treatment and rehabilitation services in Ireland' (Action 45).

In collaboration with the HSE's national office of social inclusion, the Progression Routes Initiative (PRI), a voluntary agency co-located with the Ana Liffey Drug Project in North Inner-City Dublin, has developed a project to support community and voluntary organisations and groups to implement effective policies and develop services with the aim of assessing for themselves to what extent they meet the Quality Standards in Alcohol and Drugs Services (QuADS).¹

PRI supported 30 services in 2010, and is taking on another 70 services in local and regional drugs task force areas in 2011. The work is funded by the HSE and the North Inner City Drugs Task Force. While the supports are provided free of charge, management and staff in the participating services have spent on average three hours a week over the course of 2010 implementing the process.

PRI works on the principle that quality is a journey, not a destination, a continuing process of self-reflection, change and renewal, and individual organisations and groups are invited to set their own pace in relation to assessing their

service as 'QuADS compliant'. PRI points out that payback starts almost immediately as organisations that begin to work within a sound clinical and governance framework start to provide a more efficient and effective service in a more economic, and enjoyable, manner.

Becoming QuADS compliant, with the support of PRI, occurs in two phases.

Self-review: Each organisation works through the QuADS framework, reviewing their policies and procedures against the template policies provided. The following supports are provided for this self-review and organisational change process:

- A 'policy library' is available on line. It contains more than 75 template policies, covering governance, human resources, service provision policies, service-user-related policies, and case management and care planning. These policies have been extensively researched and had editorial input from industry leaders from the health and commercial sectors. Participants are advised to adapt these policies to their own needs through an internal consultation process involving staff and service users.
- Service-specific facilitation and policy development is available on request. It is an effective way of engaging staff and management in the development of policies. Service-specific training modules are also available.

Working together for better quality in drugs services *(continued)*

- Directors seminars for all participating organisations are held approximately every quarter to facilitate interagency best-practice learning.

Peer review: After completion of the self-review phase and the integration of quality standards and procedures into all aspects of operations, an organisation or group may request a peer review. Peer review is a relatively new way of promoting and supporting organisational and sectoral development. It has been used within therapeutic communities across Europe and also in the youth services sector. In the QuADS context it will involve two organisations from within the QuADS network auditing and evaluating the work of another organisation against a standardised framework, using a specially developed IT system. Over two days these reviewers will meet with service users, staff and managers and complete a policy and file audit. The reviewers will draft a comprehensive report that will assist the organisation under review to further improve its policies, systems and procedures. The reviewers will also present an overview of their findings to a representative group of service users, staff and management, in order to ensure a cohesive and transparent process and to contribute to collective ownership of the QuADS approach.

The first 30 services to participate in the PRI QuADS support project, the '2010 Group', are currently completing Phase 1 of the process. A working group drawn from the 2010 Group is now developing terms of reference for how peer review will work in Ireland. The group is aiming, with support from PRI, to trial the Phase 2 peer review process in 2011.

Since its inception, the QuADS support project has seen a considerable rise in demand for participation from services around the country and as a result, there is a waiting list for participation in 2012.

PRI was set up five years ago by Dublin's North Inner City Local Drugs Task Force. Its purpose is 'to connect interagency service delivery with national policy, promoting good practice through pilot initiatives and the provision of practical organisational supports'. The QuADS support project is just one of its projects. Others have included a community detox pilot and a case management pilot. These two pilots resulted in the development of protocols to enhance inter-agency working, and the production of a case management guidebook, jointly published with the Homeless Agency.

(Brigid Pike)

Contacting Progression Routes

Service providers seeking information on participating in a future round of the 'QuADS compliance' project should contact staff at Progression Routes.

Caroline Gardner,
Manager,
pri@aldp.ie
01 878 6899

Aoife Dermody /
Martin Quigley,
Development Workers,
aoife.dermody@aldp.ie /
martin.quigley@aldp.ie
01 878 6899

Progression Routes has uploaded all its information and resources, including the QuADS policy library, on its website at www.progressionroutes.ie

1. For more information on QuADS, see the *Report of the HSE Working Group examining Quality & Standards for Addiction Services*. The original QuADS document for the UK is available for download at www.drugscope.org.uk/OneStopCMS/Core/SearchResults.aspx?SearchQuery=Quads

Finding our way: working together in the mental health services

A one-day symposium on working together in mental health services took place on 11 February 2011 at Hotel Minella, Clonmel, Co Tipperary. This free event was part of the South Tipperary project for change in mental health services, and was open to all mental health professionals, carers and service users in South Tipperary and Carlow/Kilkenny areas. The symposium was supported by the HSE, the Department of Health and Children and the organisation Genio.¹

The speakers included: Prof Agnes Higgins, School of Nursing and Midwifery at TCD; Dr Pat Bracken consultant psychiatrist and clinical director, Centre for Mental Health Care and Recovery, West Cork; Mr Martin Doolan and Mr David Green, Assessment Careplanning Integrated Records (ACIR), South Tipperary Mental Health Service; Ms Lorna Ní Chéirín, DCU, Mental Health Trialogue Network Initiative (MHTNI²) in Clonmel; Mr Nick Bowles, trainer in solution-focused brief therapy (SFBT) and the developer of the award-winning 'Refocusing' model for UK in-patient psychiatric units³; and Dr Yulia Kartalova-O'Doherty, researcher at the HRB.



Pictured at the symposium (l. to r.): Dr Yulia Kartalova-O'Doherty, Prof Agnes Higgins, Mr Nick Bowles, Ms Lorna Ní Chéirín, Mr David Greene, Mr Martin Doolan, Dr Pat Bracken

Finding our way (continued)

The symposium highlighted some exciting new initiatives in various mental health services, both in South Tipperary and elsewhere in Ireland, such as triologue, ACIR, and the Centre for Mental Health in West Cork. One of the key messages of the symposium was that refocusing on recovery constitutes a big change and challenge for many service users, carers and service providers. Empowerment of all stakeholders is needed in order to support and sustain this major change. Promoting teamwork and successful communication are among other big challenges facing all mental health stakeholders. The symposium helped participants to share information about their innovative work, and to discuss opportunities and challenges facing mental health services in times of economic crisis. For more details about the symposium, please contact Dr Maeve Martin at Maeve.Martin@hse.ie .

(Yulia Kartalova-O'Doherty)

1. Genio is a not-for-profit organisation working with public, private and social sector organisations to ensure that people at risk of social exclusion are supported to live full lives in their communities. For details see www.genio.ie
2. See www.mhtni.com/MHTNI/Home.html
3. See <http://preferredfutures.co.uk>

Update on drug-related deaths and deaths among drug users in Ireland

National Drug-Related Deaths Index (NDRDI) figures on drug-related deaths and deaths among drug users reported in 2008 are now available on the web.¹ Previously reported figures for the years 1998–2007 have been updated to include data received on new cases. Similarly, figures for 2008 will be revised when data relating to new cases becomes available.

Between 1998 and 2008 a total of 4,064 drug-related deaths and deaths among drug users met the criteria for inclusion in the NDRDI database. Of these deaths, 2,434 were due to poisoning and 1,630 were due to traumatic or medical causes (non-poisoning) (Table 1).

Table 1 Number of drug-related deaths, by year of death, NDRDI 1998 to 2008 (N=4,064)

| | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|---------------------------|------|------|------|------|------|------|------|------|------|------|------|
| All deaths | 241 | 270 | 258 | 277 | 338 | 296 | 368 | 454 | 503 | 535 | 524 |
| Poisoning (n=2434) | 177 | 186 | 179 | 177 | 211 | 185 | 206 | 251 | 271 | 298 | 293 |
| Non-poisoning (n=1630) | 64 | 84 | 79 | 100 | 127 | 111 | 162 | 203 | 232 | 237 | 231 |

Poisoning deaths in 2008

The annual number of deaths by poisoning increased from 177 in 1998 to 298 in 2007, and dropped slightly in 2008 to 293 (Table 1). Males accounted for the majority of deaths in each year; 72% of those who died by poisoning in 2008 were male. The majority of those who died in 2008 were aged between 20 and 44 years; the median age was 35 years.

In 2008 the greater proportion (61%) of all deaths by poisoning involved more than one substance (polysubstance cases), compared to 58% in 2007. The number of deaths where heroin was implicated rose to 86 in 2008, compared to 78 in 2007. Cocaine was implicated in 11% of all cases in the 11-year period, with the annual number dropping to 58 in 2008, compared to 78 in 2007. Prescription and over-the-counter medication was implicated in many of the deaths by poisoning. Benzodiazepines continued to play a major role in polysubstance poisonings.

For the first time since 2003, the number of deaths by poisoning recorded inside Dublin (city and county) in 2008 surpassed the number recorded outside Dublin. In 2008 the highest number of poisoning deaths were recorded in the North Dublin City and County Regional Drugs Task Force area.

Non-poisoning deaths in 2008

The annual number of non-poisoning deaths among drug users decreased slightly to 231 in 2008, compared to 237 in 2007 (Table 1). Since 2006 the number of non-poisoning cases recorded has steadied. Of the 221 cases in 2008 with a known cause of death, over half (54%, 120) were due to medical causes and the remainder (46%, 101) were due to trauma (Figure 1).

Update on drug-related deaths (continued)

Deaths due to trauma

The annual number of deaths due to trauma increased from 40 in 1998 to 114 in 2007, but decreased to 101 in 2008 (Figure 1). In 2008, sixty-one (60%) of those who died from traumatic causes were aged between 20 and 34 years. The median age was 28 years. Almost all (88, 87%) were male. The most common causes of death due to trauma were hanging and drowning.

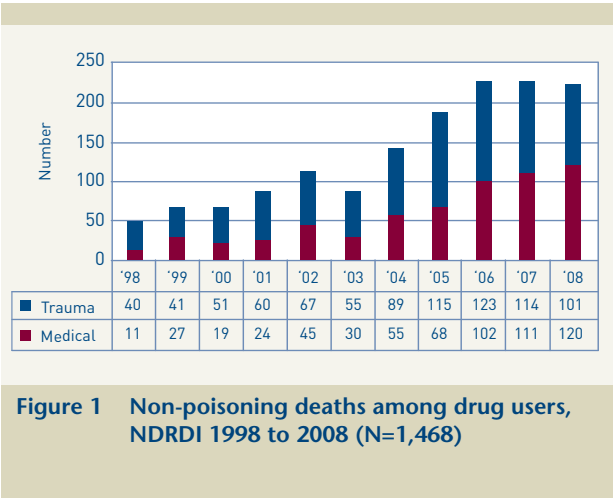
Deaths due to medical causes

The annual number of deaths due to medical causes continued to increase steadily, reaching 120 cases in 2008, when it exceeded the number of deaths due to trauma (Figure 1).

The majority of those who died from medical causes in 2008 were aged between 30 and 49 years. The median age was 42 years. Three-quarters (352, 76%) of those who died were male. The most common medical causes of death in 2008 were cardiac events (25, 21%), respiratory infections (16, 13%) and liver disease (12, 10%).

(Ena Lynn, Suzi Lyons and Simone Walsh)

- 1. Health Research Board (2011) *Drug-related deaths and deaths among drug users in Ireland: 2008 figures from the National Drug-Related Deaths Index*. Available at www.drugsandalcohol.ie/14618



Trends in alcohol and drug admissions to psychiatric facilities

Activities of Irish psychiatric units and hospitals 2009, the annual report published by the Mental Health Information Systems Unit of the Health Research Board in December 2010, shows that the total number of admissions to inpatient care has continued to fall.¹

In 2009, 1,993 cases were admitted to psychiatric facilities with an alcohol disorder, of whom 679 were treated for the first time. Figure 1 presents the rates of first admission between 1990 and 2009 of cases with a diagnosis of alcohol disorder. It is notable that the rate decreased fairly steadily in the years 1992 to 2004 and more than halved over the reporting period. The rate stabilised in 2004 and 2005, but decreased again in the years 2006 to 2009. The trend since the early nineties reflects changes in the policy and practice of alcohol treatment, and the resultant increase in community-based and special residential alcohol treatment services. Of the 2,009 discharges of cases with an alcohol disorder in 2009, 50% spent 8 days or more in hospital. Whether or not these admissions were appropriate, and in

line with the recommendations of the mental health policy, *A vision for change*, could not be discerned from the report as the numbers with co-morbid illness were not reported.

In 2009, 824 cases were admitted to psychiatric facilities with a drug disorder, of whom 313 were treated for the first time. The report does not present data on drug use and psychiatric co-morbidity, so it is not possible to determine whether or not these admissions were appropriate. Figure 2 presents the rates of first admission between 1990 and 2009 of cases with a diagnosis of drug disorder. The rate was almost three times higher in 2001 than it was in 1990. Notable dips in the rate occur in the census years 1996, 2002 and 2006, and can be partly explained by the increased population figures used as the denominator in calculating the rate for those years.

Trends in alcohol and drug admissions to psychiatric facilities *(continued)*

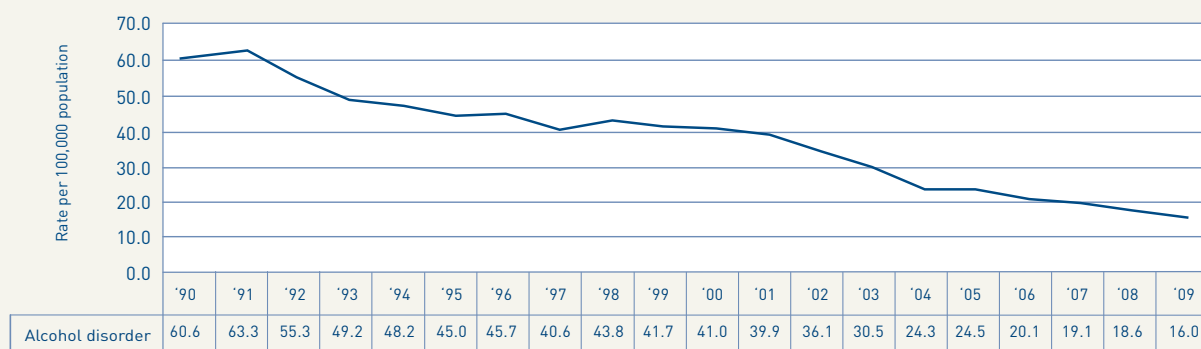


Figure 1 Rates of psychiatric first admission of cases with a diagnosis of alcohol disorder (using the ICD-10 three-character categories) per 100,000 of the population in Ireland, NPIRS 1990–2009²

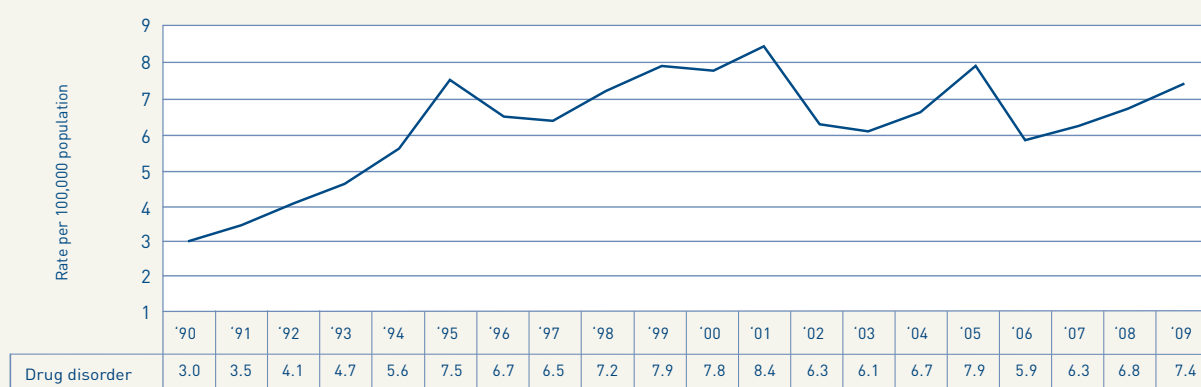


Figure 2 Rates of psychiatric first admission of cases with a diagnosis of drug disorder (using the ICD-10 three-character categories) per 100,000 of the population in Ireland, NPIRS 1990–2009²

The overall increase in the rate of drug-related first admissions between 1990 and 2001 reflects the increase in problem drug use in Ireland and its burden on the psychiatric services. The overall decrease in the rate since 2001 possibly reflects an increase in the provision of community-based specialised addiction services during this period. The increased rate in 2005 may be accounted for by the use of the 2002 census figure in calculating the rate. The decrease to 5.9 in 2006 reflects the new census figure used as denominator. The rate increased in 2008 and 2009. Of the 847 discharges with a drug disorder, 50% spent six days or more in hospital.

(Jean Long)

1. Daly A and Walsh D (2010) *Activities of Irish psychiatric units and hospitals 2009: main findings*. HRB Statistics Series 9. Dublin: Health Research Board. www.hrb.ie/publications/hrb-publication/publications//535/
2. Annual reports from the National Psychiatric In-patient Reporting System (NPIRS) for the years 1990 to 2009 are available on the Health Research Board website at www.hrb.ie/publications/mental-health

Problematic alcohol use among methadone users: update on a HRB-funded study

Problematic alcohol use is common among injecting drug users and is known to be associated with adverse health outcomes. Recently published systematic reviews¹ have demonstrated the role of primary care in screening and treatment for problematic alcohol use and the importance of a stepped approach to alcohol treatment, whereby hazardous or harmful alcohol use benefits from more intensive or specialised treatment.

The UCD School of Medicine, in conjunction with the University of Limerick, Trinity College Dublin and HSE Addiction Services, is conducting a study on problem alcohol use among people with opiate dependency in primary care. The research team is led by Professor Walter Cullen and the study is funded by the Health Research Board (HRB).

The aim of the study, 'Towards optimum care of problematic alcohol use among patients with opiate dependency', is to inform and improve the screening and treatment of problem alcohol use among methadone users in primary care by:

- describing both users' and providers' experiences of and attitudes towards such screening and treatment;
- developing a complex intervention to improve screening and treatment rates;
- determining the views of professionals and patients regarding optimal implementation of this complex intervention.

This qualitative study is being carried out in three phases in the east coast.

In the first phase, 57 healthcare professionals and methadone users from 23 randomly selected GP practices

and specialist addiction services were interviewed about their experience of and attitudes towards screening and treatment for problematic alcohol use.

In phase two, the researchers aim to develop clinical guidelines for screening and treatment for problem alcohol use among drug users. These guidelines will be informed by the findings of the interviews conducted in phase one, by expert opinion obtained through a facilitated expert consensus process, and by a Cochrane systematic review.

Phase three will begin once the guidelines have been developed. The researchers will again seek the opinions of healthcare professionals and methadone users in focus groups on how the guidelines should best be implemented.

The research team is currently looking for interested professionals in the areas of primary care, drug or alcohol addiction treatment (in and outpatient), public health, psychiatry or hepatology to participate in the process. Interested professionals in general practice or general medicine, services users and community organisations are also very welcome to become involved.

For more information, or to join the multidisciplinary group developing clinical guidelines, please contact the researchers at 01 4730893 or by email: catherine-anne.field@ucd.ie or jan.klimas@ucd.ie.

(Suzi Lyons)

1. See, for example, Kaner E *et al.* (2009) The effectiveness of brief alcohol interventions in primary care settings: a systematic review. *Drug and Alcohol Review*, 28(3): 301–23.

Report highlights the benefits of community-based drug projects

Youth Work Ireland Cork (YWIC) published a report, *Youthwork as a response to drugs issues in the community*,¹ in January 2011. The report was officially launched by Brian Crowley MEP in University College Cork.

The research was commissioned by YWIC and was undertaken by Mr Pat Leahy, School of Applied Social Studies, UCC, and two students from the Bachelor of Social Work undergraduate degree course.

The report highlights the effectiveness of small, locally based harm reduction projects that feature dedicated and skilled workers in dealing with drug-related issues. The key findings of the study, as published in the executive summary of the report (pp. 1–2), are reproduced below.

- A social rather than medical or legal based response to drugs issues offers policy makers and practitioners a genuinely holistic methodology for effective intervention.
- A local rather than universal response rooted in harm reduction allows for cultural, geographical and community factors to dictate the nature of an intervention.



Authors of the report: (l. to r.) Pat Leahy, Emma Bennett and Aoife Farrell, with Brian Crowley MEP and the Lord Mayor of Cork, Michael O'Connell

- Effective praxis in this field requires skilled, independent, reflexive, motivated and creative practitioners operating within a supportive agency setting.

Report highlights the benefits of community-based drug projects *(continued)*

- A clear theoretical framework encompassing knowledge of young people, drugs work, human behaviour and communities is a fundamental prerequisite to best practice.
- A high degree of service visibility in the community and easy access to the services is required.
- Community based projects work effectively with service users who will never enter treatment; they offer drug users an effective alternative to medicalised responses.
- In many cases inappropriate and problem drug use is a consequence of social inequality; interventions that can respond to these social issues in (particularly disadvantaged) communities offer the people who suffer from drugs issues a far more comprehensive range of services than a medicalised response.
- Human contact between the service user and the practitioner in the form of a relationship founded on trust is the key building block of success.
- In terms of cost effectiveness community based projects offer excellent value for money; the overwhelming majority of funding is used in the provision of frontline services.

(Anne Marie Carew)

1. Leahy P, Bennet E and Farrell A (2011) *Youthwork as a response to drugs issues in the community. A report on the Gurrabraher–Churchfield Drugs Outreach Project: profile, evaluation, and future development*. Cork: Youth Work Ireland Cork. www.drugsandalcohol.ie/14610

Update on blood-borne viral infections in injecting drug users

HIV surveillance in 2009

Voluntary linked testing for antibodies to HIV has been available in Ireland since 1985. According to the most recent report of the Health Protection Surveillance Centre (HPSC),¹ at the end of 2009 there were 5,369 diagnosed HIV cases in Ireland, of which 1,447 (27%) were probably infected through injecting drug use.

Figure 1 presents the number of new cases of HIV among injecting drug users reported in Ireland, by year of diagnosis; data from 1982 to 1985 were excluded from the figure as these four years were combined in the source records. There was a fall in the number of HIV cases among injecting drug users between 1994 and 1998, with about 20 cases per year, compared to about 50 cases each year in the preceding years. There was a sharp increase in the number of cases in

1999 (69 new cases), which continued into 2000 (83 new cases). Between 2001 and 2009 there was an overall decline in the number of new injector cases (38, 50, 49, 71, 66, 57, 54, 36 and 30 respectively) when compared to 2000. It was difficult to interpret the trend owing to the relatively small numbers diagnosed each year, so a smoother curve (red plot line in Figure 1) was calculated using a rolling centred three-year average. This curve presents a new baseline of between 40 and 60 cases each year since 2006 and a declining trend.

Of the 30 new HIV cases among injecting drug users reported to the HPSC in 2009, 24 were male and six were female, and the average age was 36 years (range 22–57). Nineteen of the 30 cases with a known address lived in Dublin, Kildare or Wicklow.

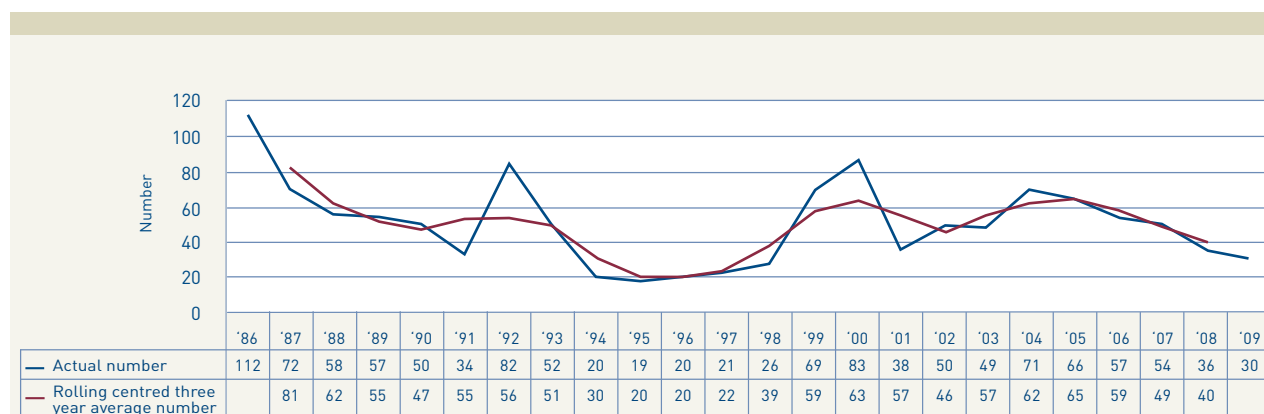


Figure 1 Actual number and rolling average number of new cases of HIV among injecting drug users, by year of diagnosis, reported in Ireland, 1986–2009

Source: Unpublished data reported to Department of Health and Children, National Disease Surveillance Centre and HPSC.

Update on blood-borne viral infections in injecting drug users *(continued)*

Hepatitis B surveillance in 2009

Hepatitis B is a vaccine-preventable disease which is transmitted through contact with the blood or body fluids of an infected person. The main routes of transmission are mother-to-baby, child-to-child, sexual contact and unsafe injections. The number of cases notified to the HPSC increased in 2007 and 2008, but decreased by 12% in 2009, when it fell from 931 to 820. Of the 820 cases in 2009, 647 had a chronic infection, 78 had an acute infection and the disease status of 95 cases was unknown. The surveillance

system has recorded risk factor data since 2004. The percentage of cases notified to the HPSC that included data on risk factors fell from 60% in 2008 to 44% (358 cases) in 2009 (Table 1). Of these 358 cases, ten (2.8%) reported injecting drug use as their main risk factor. The number of cases who reported injecting drug use remained consistently low between 2005 and 2009, indicating the effectiveness of routine administration of the hepatitis B vaccine to such cases.

Table 1 Acute and chronic hepatitis B cases reported to the HPSC, by risk factor status, 2007–2009

| | Hepatitis B status | | | | | | | | | | | | | | | | | |
|--------------------------------|--------------------|------|---------|------|---------|------|------------|------|---------|------|---------|------|------------|------|---------|------|---------|------|
| | 2007 | | | | | | 2008 | | | | | | 2009 | | | | | |
| | Acute | | Chronic | | Unknown | | Acute | | Chronic | | Unknown | | Acute | | Chronic | | Unknown | |
| | n | % | n | % | n | % | n | % | n | % | n | % | n | % | n | % | n | % |
| All cases | 52 | 6.0 | 705 | 82.0 | 103 | 12.0 | 82 | 8.8 | 747 | 80.2 | 102 | 11.0 | 78 | 9.5 | 647 | 78.9 | 95 | 11.6 |
| Cases with risk factor data | 44 | 84.6 | 314 | 44.5 | 16 | 15.5 | 73 | 89.0 | 427 | 57.2 | 55 | 53.9 | 57 | 73.1 | 277 | 42.8 | 24 | 25.3 |
| Of which: | | | | | | | | | | | | | | | | | | |
| Injecting drug users | 1 | 2.3 | 5 | 1.6 | 1 | 6.3 | 0 | 0 | 6 | 1.4 | 1 | 1.8 | 1 | 1.8 | 9 | 3.2 | 0 | 0 |
| Cases without risk factor data | 8 | 15.4 | 391 | 55.5 | 87 | 84.5 | 9 | 11.0 | 320 | 42.8 | 47 | 46.1 | 21 | 26.9 | 370 | 57.2 | 71 | 74.7 |
| Total | 860 | | | | | | 931 | | | | | | 820 | | | | | |

Source: Unpublished data from the HPSC

Hepatitis C surveillance in 2009

Hepatitis C is one the most common blood-borne viral infections among injecting drug users and is transmitted through contact with the blood of an infected person. The main routes of transmission are mother-to-baby, unsafe injections, transfusion of blood and blood products, and unsterile tattooing and skin piercing. There were 1,255 cases of hepatitis C reported to the HPSC in 2009 (Table 2), compared to 1,527 cases in 2008.

Table 2 Hepatitis C cases and notification rates per 100,000 population, 2004–2009

| Year | n | Notification rate |
|------|------|-------------------|
| 2004 | 1126 | 26.6 |
| 2005 | 1409 | 33.2 |
| 2006 | 1217 | 28.7 |
| 2007 | 1552 | 36.6 |
| 2008 | 1527 | 36.0 |
| 2009 | 1255 | 29.6 |

Source: Unpublished data from the HPSC

An enhanced surveillance system for hepatitis C was introduced in Ireland in 2007. Enhanced surveillance is essential to identify risk factors and for planning prevention and treatment strategies. In 2009, 40% of newly reported hepatitis C cases had risk factor status reported (Table 3). As expected, the majority of these cases (70.9%) reported injecting drug use as the main risk factor. Four per cent of cases said that they had been recipients of blood or blood products at some time in the past and, according to the HPSC, were late reports to the system (N Murphy, HPSC, personal communication, 2009).

In 2009, 83% of cases reporting injecting drug use as their main risk factor were notified by services in Dublin, Kildare and Wicklow (Table 4). Seventy-three per cent were male and 62% were under 35 years old.

Update on blood-borne viral infections in injecting drug users *(continued)*

Table 3 Hepatitis C cases reported to the HPSC, by risk factor status, 2007–2009

| | 2007 | | 2008 | | 2009 | |
|--|------|------|------|------|------|------|
| Risk factor status | n | % | n | % | n | % |
| Total number of cases | 1552 | | 1527 | | 1255 | |
| Cases <i>with</i> reported risk factor data | 662 | 42.7 | 575 | 37.7 | 506 | 40.3 |
| Of which: | | | | | | |
| Injecting drug users | 505 | 76.3 | 442 | 76.9 | 359 | 70.9 |
| Recipients of blood/blood products | 31 | 4.7 | 23 | 4.0 | 20 | 4.0 |
| Other risk factors | 90 | 13.6 | 78 | 13.6 | 80 | 15.8 |
| No known risk factor identified by patient or doctor | 36 | 5.4 | 32 | 5.6 | 47 | 9.3 |
| Cases <i>without</i> reported risk factor data | 890 | | 952 | | 749 | |
| Source: Unpublished data from the HPSC | | | | | | |

Table 4 Hepatitis C cases who reported injecting drug use as a risk factor, by age, gender and place of residence, 2007–2009

| | 2007 | | 2008 | | 2009 | |
|--|------|------|------|------|------|------|
| | n | % | n | % | n | % |
| Total number of known injector cases | 505 | | 442 | | 359 | |
| Gender | | | | | | |
| Male | 338 | 66.9 | 316 | 71.5 | 261 | 72.7 |
| Female | 166 | 32.9 | 124 | 28.1 | 96 | 26.7 |
| Unknown | 1 | 0.2 | 2 | 0.5 | 2 | 0.6 |
| Age | | | | | | |
| Mean age | 32.8 | | 33.2 | | 34.1 | |
| Median age | 31 | | 31.5 | | 33 | |
| Under 25 years | 48 | 9.5 | 45 | 10.2 | 35 | 9.7 |
| 25 to 34 years | 284 | 56.2 | 231 | 52.3 | 189 | 52.6 |
| Over 34 years | 171 | 33.9 | 162 | 36.7 | 134 | 37.3 |
| Age not known | 2 | 0.4 | 4 | 0.9 | 1 | 0.3 |
| Place of residence | | | | | | |
| Dublin, Kildare or Wicklow | 448 | 88.7 | 377 | 85.3 | 299 | 83.3 |
| Elsewhere in Ireland | 57 | 11.3 | 65 | 14.7 | 60 | 16.7 |
| Source: Unpublished data from the HPSC | | | | | | |

(Jean Long)

1. Jackson S, O'Donnell K, Moran J and O'Hora A (2010) *HIV & AIDS in Ireland 2009*. Dublin: Health Protection Surveillance Centre.

Barriers to and facilitators of hepatitis C testing

Hepatitis C infection is common among injecting drug users (IDUs), yet access to hepatitis C care, particularly treatment, is suboptimal. There has been little in-depth study of IDUs' experiences of what enables or prevents them engaging at every level of hepatitis C care, including testing, follow-up, management and treatment processes.

A qualitative study aimed to explore these issues with current and former IDUs in the greater Dublin area.¹ Between September 2007 and September 2008 in-depth interviews were conducted with 36 service users across a range of primary and secondary care services, including two addiction clinics, a general practice, a community drop-in centre, two hepatology clinics, and an infectious diseases clinic. Interviews were analysed using a grounded theory approach.

Of the 36 participants interviewed, 28 were men and eight were women. They ranged in age from 24 to 54 years, with a median age of 32 years. The median reported age at first injecting drugs was 18.5 years (range 14–29 years). Of the 28 who reported their main problem drug, 79% reported heroin and 21% cocaine. Thirty-three (91%) participants reported testing positive for hepatitis C, of whom four (11%) reported HIV/HCV co-infection.

Among the factors influencing access to and uptake of HCV care were:

- perceptions that every injector had this invisible infection (hepatitis C) and that its effects were not as serious as those of HIV;

- perceptions that the investigations and treatments for hepatitis C were more severe than the infection itself;
- use of coping strategies, such as blocking awareness, escape, support and positive thinking, to deal with fears about the future effects of hepatitis C, or anxieties about investigations or treatment;
- the quality of relationships with health care providers;
- contact with services, encouraging and caring doctors and nurses, family ties, recovery from addiction, and convenient access to testing and treatment; and
- continued substance use, employment (lack of free time), contraindications to treatment, lack of reminders and lack of opportunity.

In conclusion, IDUs face multiple barriers to HCV care but a range of facilitators were identified that could increase access to and uptake of treatment.

(Jean Long)

1. Swan D, Long J, Carr O, Flanagan J, Irish H, Keating S *et al.* (2010) Barriers to and facilitators of hepatitis C testing, management, and treatment among current and former injecting drug users: a qualitative exploration. *AIDS Patient Care and STDS*, 24(12): 753–762. www.drugsandalcohol.ie/14416

External review of methadone treatment protocol makes wide-ranging recommendations

The results of the first external review of the Irish methadone treatment protocol were published on 20 December 2010.¹ The HSE commissioned Michael Farrell, professor of addiction psychiatry at Kings College London, to conduct the review, assisted by Joe Barry, professor of population health medicine at Trinity College Dublin. This is the second review of the protocol; the Methadone Prescribing Implementation Committee carried out an internal review in 2005.²

The terms of reference for the external review were to review the methadone treatment protocol with regard to:

- maximizing provision of treatment, including detoxification, stabilisation, and rehabilitation;
- clinical governance and audit;
- effectiveness of referral pathways;
- the enrolment and training of GPs, the criteria for Level 1 and Level 2 GPs, and the GP co-ordinator role;
- the appropriateness and efficacy of urinalysis testing;
- data collection, collation and analysis; and
- engagement with the Department of Justice on the prescribing of methadone in Garda stations.

The review was informed by 69 written submissions and the conclusions of 38 oral hearings with stakeholders on the impact of the protocol. The main points of these inputs are outlined in chapter 5 and appendix 2 of the report. The authors state that the original protocol achieved its aims, especially in relation to improving both poor prescribing and the quality of independent practitioner practice. The current review covers a wide range of new issues, including: developing a model of service for rural Ireland, promoting better integration between and among services, the need to review benzodiazepine prescribing, changing the regime of urine testing and the need to deal urgently with methadone prescribing in Garda stations.

The list of recommendations below, extracted in an abridged form from the published report, give an overview of the scope of the review. The full text of the recommendations is on pp. 33–36 of the report.

1. **Maximising treatment provision and the efficacy of referral pathways**
 - 1.1. Requests for detoxification should have a defined time frame for response and should be reviewed as part of a service audit process.

External review of methadone treatment protocol *(continued)*

- 1.2. There should be a mechanism to rapidly access treatment for the six months after detoxification to ensure support if relapse occurs.
- 1.3. The redrafting of the methadone regulations to incorporate buprenorphine (alone or with naloxone) treatment should be completed to ensure a broader range of treatment options. To this end, the title needs to be changed and could be "The Opioid Treatment Protocol".
- 1.4. Services with a focus on key workers and multidisciplinary work should be promoted and developed.
- 1.5. An integrated services approach should account for family, community and user groups and it is recommended that these voices get a more prominent place in the future planning and development of drug services.
- 1.6. There is an urgent need for a service model outside of Dublin that has a clear focus on rural aspects of service delivery.
- 1.7. In areas where the service currently relies on doctors travelling from Dublin, it is desirable that more permanent local medical input is organised in the near future for the purposes of continuity of service delivery.
- 1.8. The professional expertise of the adolescent services and the midwifery services should be used for developing an overall national strategy in these specific topics.
- 1.9. Implementation of a once-yearly brief instrument, such as the Treatment Outcome Profile, would provide important information on the performance of individuals and on the overall performance of the service. There is need to create a sense of progression and promote movement within and between services.
- 1.10. Services should use the full range of skills of the multidisciplinary team to ensure that health and social problems of drug users is evenly addressed.
- 1.11. The treatment of Hepatitis C Virus among drug users needs to be expanded further.
- 1.12. There is a need to develop a more structured and explicit care planning process. Everyone should have a clearly documented care plan that is regularly reviewed and updated, drawn up within the first three months of treatment.
- 1.13. The development of an electronic record of care planning is necessary if proper care planning is to be comprehensively implemented.
- 2. Clinical governance and audit**
 - 2.1. It is desirable that there be some option for flexibility around the appointment of HSE clinical directors and that the director has a background and training to the level recognised as an Addiction Specialist.
 - 2.2. The lines of reporting and accountability for professionals in all of the services to be clarified.
 - 2.3. Audit should now be developed across the full range of drug services where standards around practice could be reviewed.
 - 2.4. The audit process should also be used to monitor treatment drop-out.
 - 2.5. The development of joint guidelines that would enable benchmarks to be set against which future audits could be measured. Such guidelines should be developed by a joint working group of the College of Psychiatry of Ireland and the ICGP with input from relevant other professional groups.
- 2.6. There is a need to link major expansion in delivery of drug treatment to prisoners with the community based services.
- 2.7. The Pharmaceutical Society of Ireland demonstrated an interest in playing a part in improving the standards of prescribing of benzodiazepines. This work needs further development and should be undertaken as soon as possible in order to reduce poor benzodiazepine prescribing practice across all sectors of services in the HSE.
- 2.8. Recommendation 10 from the *Report of the Benzodiazepine Prescribing Committee (2002)*³ should be implemented.
- 3. Enrolment of GPs, training of GPs, the criteria for level 1 and level 2 GPs, and the GP Co-ordinator role**
 - 3.1. It should be an expectation that all trainees completing GP professional training have demonstrable competence to meet criteria for level 1.
 - 3.2. There is a need to expand the number of level 2 general practitioners.
 - 3.3. There should be a stated time limit for patients to be with level 2 GPs and GP Co-ordinators should ensure that the patient moves on to a level 1 GP within 12 months.
 - 3.4. Level 2 GPs are requesting a change of the cap on numbers to be raised from 35 to 50. We recommend that this be done.
 - 3.5. The cap on the number of patients with level 1 GPs should be abolished.
 - 3.6. The roles of the GP Co-ordinators should be overhauled and the task of moving patients from level 2 to level 1 GPs be prioritised, in conjunction with local management.
 - 3.7. The model of GP nurse liaison practitioners who work to both support and move patients on should be further developed.
 - 3.8. As new structures evolve the National GP Co-ordinator post should be reviewed.
- 4. Urinalysis testing, its appropriateness and efficacy**
 - 4.1. Frequent urine testing should be stopped.
 - 4.2. The supervision of urine testing should be eliminated except where there is a legal requirement for supervision and that oral fluid or temperature testing be used to indicate whether a fresh sample is being provided.
 - 4.3. The technology behind oral fluid testing has improved substantially and it is now possible to undertake on site saliva testing.
 - 4.4. The clinical guidelines jointly developed by the ICGP and the College of Psychiatry of Ireland should include an implementation plan for the move to less urine testing and a greater clinical focus on the use of the results of drug testing samples.
 - 4.5. Consideration should be given to piloting one or two contingency management treatment programmes to assess their viability.

External review of methadone treatment protocol *(continued)*

- 4.6. It would be desirable to introduce a mechanism for periodic monitoring of the levels of supervision of substitution treatment.
5. **Methadone prescribing in Garda stations**
- 5.1. There is a need for a fundamental review of the procedures and systems for medical assessment of people in Garda custody.
- 5.2. There is a need for clear and explicit guidelines for the management of opioid dependence while in Garda custody. A working group with a relevant range of stakeholders should be urgently established.
- 5.3. The overall health care input to Garda stations should be reviewed with consideration that operational responsibility and financial aspects of this service be transferred to become a responsibility of the HSE.
- 5.4. The doctors attending Garda stations should be at a minimum level 2 trained GPs.
- 5.5. Doctors attending users in Garda stations should have access out of hours to the CTL and should also be able to obtain information from Pharmacists on the last time of medication dispensing.
- 5.6. Garda stations should come under the protocol.
6. **Data collection, collation and analysis**
- 6.1. In developing a care planning approach, consideration should be given to the broader utility of this data monitoring with a view to some brief outcome monitoring process being built into this, where the status of an individual is systematically recorded on a once-yearly basis.
- 6.2. There should ideally be a systematic approach that enables wider data linkage through possible use of the PPS number that would enable ongoing mortality and other service utilisation analysis. Such work would help in tracking the pathways and careers of service users and provide valuable information on the long term outcomes of users.
- 6.3. There is a need for legislative change to allow the linkage of data from different data sources.
- 6.4. We recommend the establishment of a group comprising the main data controllers so that maximum use can be made of the data collected, in a secure and confidential environment with appropriate privacy protection.
7. **Other**
- 7.1. Handwriting exemption procedures should be introduced.
- 7.2. Nurse prescribing of controlled drugs should be explored and if possible developed further in line with international practice.
- 7.3. There is a need for better linkage and for ensuring priority access of prisoners to community based treatment after release from prison from all Irish prisons.

(Suzi Lyons)

1. Farrell M and Barry J (2010) *The introduction of the Opioid Treatment Protocol*. Dublin: Health Service Executive. Available at www.drugsandalcohol.ie/14458
2. Methadone Prescribing Implementation Committee (2005) *Review of the Methadone Treatment Protocol*. Dublin: Department of Health and Children. Available at www.drugsandalcohol.ie/5962
3. Benzodiazepine Committee (2002) *Report of the Benzodiazepine Committee*. Dublin: Department of Health and Children. Available at www.drugsandalcohol.ie/5348

Treated opiate users: alcohol use and treatment outcomes

Researchers analysed data from the Research Outcome Study in Ireland Evaluating drug treatment effectiveness (ROSIE) study to investigate alcohol use among opiate users and associated treatment outcomes.¹ The aim of the research was to examine the frequency and quantity of alcohol use among opiate users at entry to treatment and at follow-up to establish 'whether the success rate of a program may be, in part, related to the alcohol using habits of the client'.

ROSIE was the first national, prospective longitudinal opiate drug treatment outcome study to be done in Ireland. The study recruited 404 new opiate drug-treatment clients in 2003/2004. These were followed up at one year (76% re-interviewed) and at three years (88% re-interviewed).² The mean age of the participants was 27 years, and 72% were men.

For the purposes of the study described here, data relating to 242 of the original ROSIE intake were classified according to the participants' alcohol usage. The three categories used were: abstainers (had not drunk in the past 90 days); medium drinkers (consumed up to 70g (men) or 50g (women) of alcohol per typical using day); and heavy drinkers (consumed more than 70g (men) or 50g (women) per typical using day). The analysis showed that at the start of the study 49% of men and 43% of women were defined as heavy drinkers. At the three-year follow-up, the

proportion of heavy drinkers had dropped for both groups – to 26% of men and 28% of women.

The association between alcohol use and crime, health, employment, personal finances, and drug usage was investigated. The study found that abstainers were the lowest offenders in terms of certain crimes, including assault. Logistic regression was used to investigate the link between drinking and drug usage at the three-year follow-up. It was found that abstainers used heroin and other drugs less frequently.

The authors state that their results show that the link between drug and alcohol use is complex, and that other factors, such as gender, age and ongoing or changing alcohol and drug usage, need to be considered when assessing and planning treatment for opiate users in order to target their treatment effectively.

(Suzi Lyons)

1. Stapleton R and Comiskey C (2010) Alcohol usage and associated treatment outcomes for opiate users entering treatment in Ireland. *Drug and Alcohol Dependence*, 107: 56–61.
1. For more information and results from the original ROSIE study, see www.nuim.ie/rosie

Legal update

This update covers drug-related Acts and Bills of the Oireachtas introduced or progressed during 2010 and up to the dissolution of the 30th Dáil (Parliament) in February 2011. It also identifies new substances brought under control within the terms of the misuse of drugs legislation.

Acts to control new psychoactive substances

The *National Drugs Strategy (interim) 2009–2016* (NDS) flagged as an emerging issue the sale in Ireland of psychoactive substances that were not in breach of the existing law, commonly referred to as 'legal highs'; these substances were generally being sold in 'head shops'. Actions 14 and 15 in the NDS called for ongoing monitoring of the legislative framework.¹ Subsequently, as head shops continued to multiply across the country at a rapid rate, the government gave priority to implementing these two actions.²

The **Misuse of Drugs Act 1977 (Controlled Drugs) (Declaration) Order 2010** made on 11 May 2010 declared a range of legal highs to be controlled drugs. Three associated Statutory Instruments signed on the same day gave effect to the Order. Under this legislation, approximately 200 individual legal high substances, which had been on sale in head shops, and which included the vast majority of products of public health concern, were declared to be controlled drugs. They include broadly:

- synthetic cannabinoids (contained in SPICE products);
- benzylpiperazine (BZP) and piperazine derivatives (commonly known as 'party pills');
- mephedrone, methylone, methedrone, butylone, flephedrone, MDPV (i.e. cathinones, often sold as bath salts or plant food);
- gamma butyrolactone (GBL) and 1,4 butanediol;
- ketamine and tapentadol (substances that have legitimate medicinal use but which can be subject to misuse); and
- certain narcotic and psychotropic substances that Ireland is obliged to bring under control in order to comply with UN conventions.

The **Criminal Justice (Psychoactive Substances) Act 2010** came into force in August 2010. This legislation was enacted to introduce more general control by way of criminal justice legislation to deal with head shop products as they emerged. The Act also gives appropriate powers to the gardaí and to the courts to intervene quickly, by way of prohibition notices and prohibition orders, to prevent the sale of psychoactive substances.

The Act includes the following provisions:

Section 3 provides for the offences of selling, importing and exporting psychoactive substances for human consumption. Section 3 (1) provides for the offence of selling a psychoactive substance, knowing or being reckless as to whether it is being acquired or supplied for human consumption.

Section 4 creates the offence of selling an object, knowing that it will be used to cultivate by hydroponic means any plant. Hydroponic cultivation is the cultivation of plants in liquid containing nutrients, without soil, and under controlled conditions of light, temperature and humidity.

This method of cultivation is known to be used for the purpose of growing cannabis indoors.

Section 5 provides for the offence of advertising a psychoactive substance or object to which Section 4 applies.

Section 7 provides that a Garda Superintendent (or higher) may serve a prohibition notice on a person where he or she believes that the person is selling, importing or exporting psychoactive substances for human consumption, selling objects for use in cultivating by hydroponic means any plant.

Section 20 provides that a person guilty of an offence under the Act is liable on summary conviction to a fine of up to €5,000 or imprisonment for up to 12 months or both, or on conviction on indictment to a fine or to imprisonment not exceeding 5 years or both.

Following the introduction of the Act, the Gardaí visited head shops in early September; only 19 were open and none were selling psychoactive substances (Garda Síochána, personal communication, 2010). A number of Bills proposed by opposition parties in the Dáil in 2010 in relation to the head shops issue are listed in the table overleaf.

Other new Acts applicable to drug offences

- The **Criminal Justice (Money Laundering and Terrorist Financing) Act 2010** provides for offences of, and related to, money laundering in and outside the State; to give effect to Directive 2005/60/EC of the European Parliament and of the Council of 26 October 2005 on the prevention of the use of the financial system for the purpose of money laundering and terrorist financing.
- The **Criminal Procedure Act 2010** makes provision for a modification of the rule against double jeopardy in order to allow a person who has been acquitted of an offence to be re-tried in circumstances where new and compelling evidence emerges or where the acquittal is tainted due, for example, to corruption or intimidation of witnesses or jurors or perjury. The rule against double jeopardy provides that no person may be put at risk of being punished twice for the same offence. The legislation applies to a number of drug-related offences.
- The **Road Traffic Act 2010** provides for a reduction in the blood alcohol content (BAC) limit for drivers and also provides powers to assist the Garda Síochána in forming an opinion as to whether a driver is under the influence of an intoxicant (drug or drugs) and to carry out a preliminary impairment test on such drivers.
- The **Criminal Justice (Public Order) Act 2011** prohibits harassment or intimidation of members of the public by persons who engage in begging and confers powers on members of the Garda Síochána to give directions to persons to desist from begging, in certain circumstances such as where they are begging near cash machines or in front of places of business. It also provides for a series of sanctions including fines and possible imprisonment for breaches of the law.
- The **Communications (Retention of Data) Act 2011** requires service providers, those engaged

Legal update *(continued)*

in the provision of a publicly available electronic communication service or a public communication network by means of fixed line or mobiles or the internet to retain data relating to fixed and mobile telephony, for 1 year, and data relating to internet access, internet email and internet telephony for 2 years, and provides for disclosure in relation to the investigation of specified offences including Customs offences.

Status of Bills before the Dáil

Bills before the Dáil at that time of its dissolution on 1 February 2011 are deemed to have lapsed. It is for the new government to decide whether they will be restored in the new Dáil. Current status of relevant Bills is shown in the table below.

| Title and explanatory memorandum | Status |
|---|--|
| The Spent Convictions Bill 2007 (No 48 of 2007) is intended to apply where a prison sentence not exceeding six months or a fine or penalty have been imposed, and then only after a certain number of years have elapsed without a further conviction. The purpose of the Bill is to help rehabilitate convicted persons through facilitating their reintegration into the workforce and allowing them to build new careers. | Publication expected during Summer Session 2011 |
| The Criminal Justice (Forensic Evidence and DNA Database System) Bill 2010 (No 2 of 2010) , among other things, replaces the existing statutory and common law arrangements governing the taking of samples for forensic testing from suspects for use as evidence in criminal investigations and proceedings with an updated statute-only regime, provides for the establishment of a DNA database system for use by the Garda Síochána as an intelligence source for criminal investigations, provides for the taking of samples for the purposes of the DNA Database System and other matters relating to the System, and implements the DNA-related elements of the Council Decision 2008/615/JHA of 23 June 2008 on the stepping up of cross-border co-operation, particularly in combating terrorism and cross-border crime. | Heads have been agreed and text is being drafted |
| The Planning and Development (Amendment) Bill 2010 (No 10 of 2010) provides that a change of use of a structure to use as a head shop or a sex shop shall not be exempted development, so as to ensure that such premises would have to obtain planning permission under the relevant planning legislation. | Publication expected late 2011 |
| The Non-Medicinal Psychoactive Substances Bill 2010 (No 18 of 2010) establishes a new body known as the Non-Medicinal Psychoactive Substances Regulatory Authority. This Authority will regulate the sale, production, import, distribution and marketing of non-medicinal psychoactive substances and products that can have an effect on perception, health and wellbeing when consumed or otherwise used by persons. | Lapsed |
| The Proceeds of Crime (Amendment) Bill 2010 (No 30 of 2010) amends the Proceeds of Crime Act 1996. The purpose of the Bill is to reduce from 7 years to 2 years the waiting period before the Criminal Assets Bureau can apply to the High Court for the disposal and forfeiture of assets frozen under section 3 of the Proceeds of Crime Act 1996. | Lapsed |

(Johnny Connolly)

1. Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009–2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs. Actions 14 and 15.
2. Department of Health and Children (2010) *Opening statement for meeting of Joint Committee on Health and Children in relation to recent legislation made to control certain substances under the Misuse of Drugs Act 1977*. Press release issued 1 June 2010. Available at www.dohc.ie/press/releases/2010/10100601.html

Council of Europe highlights drug-related violence in Irish prisons

The availability of drugs, the existence of feuding gangs, and overcrowding have been identified as factors contributing to 'high rates of inter-prisoner violence in Mountjoy prison', according to a report by the Council of Europe's Committee for the prevention of torture and inhuman or degrading treatment or punishment (CPT).¹ Although the CPT acknowledges a number of measures which have been taken to address safety concerns since its visit in 2006, Mountjoy Prison, it states, 'remains unsafe for prisoners and prison staff alike. ... Stabbings, slashings and assaults with various objects are an almost daily occurrence' (p. 21).

The CPT delegation observed that drug misuse remains a 'major challenge' in all prisons visited, and that 'management and health-care staff in most prisons visited acknowledged both the rising numbers of prisoners with a substance abuse problem and the widespread availability of drugs' (p. 41).

The CPT acknowledges that, since its visit in October 2006, further investment has been made to implement the Irish Prison Service drug strategy through initiatives such as the provision of detoxification, methadone maintenance, education programmes, addiction counselling and drug therapy programmes. However, the CPT states that it has 'serious concerns over the manner in which methadone prescribing is carried out in Cork, Midlands and Mountjoy Prisons' (p. 41).

Methadone, according to the CPT, should only be prescribed as part of a comprehensive drug treatment programme that includes engagement with 'addiction counsellors, addiction nurses and as required an addiction psychiatrist' (p. 42). Furthermore, it states: 'The dose of methadone prescribed as maintenance should be that required to stabilise a prisoner's drug use to the extent that the inmate injects or uses opiates less frequently and remains in contact with prison addiction services' (p. 42). These practices were not observed at either Midlands or Mountjoy prisons, where, according to the CPT, there were a number of serious shortcomings. Prisoners who were on a methadone prescription at the time of admission 'often merely had the dose continued and were not required to engage with the addictions counsellor ... many of the methadone prescriptions were illegible ... there was a lack of medical review of the prescription ... there was no reference to the frequency of drug use, including injecting, or to the nature of illicit drugs consumed; for example, monitoring through regular analysis of urine' (p. 42). At Midlands prison 'urinalysis results were not annotated in prisoners medical records; apparently, they were not even kept at the prison' (p. 42).

A further concern related to the prescription of methadone as a detoxification agent either upon admission to prison or when an inmate identified him/herself as having an illicit drug use problem. The absence of any assessment as to whether a prisoner was likely to suffer from drug withdrawal subsequent to admission and the practice of placing a prisoner who gave a history of drug use on a three-week methadone detoxification programme were also highlighted in the report. Given that there was no routine follow-up of withdrawal or other symptoms and no assessment as to whether prisoners were continuing their illicit drug use

on top of the prescribed methadone detoxification, the delegation concluded that 'for a number of prisoners in receipt of a methadone detoxification prescription it could be stated that this was simply "free petrol"' (p. 42).

The CPT also notes the additional measures taken to prevent drugs entering prisons, such as security checks on staff and visitors, the development of canine drug detection units, the introduction of mandatory drug testing, booked visits and improved intelligence gathering. It states that the effectiveness of these measures should be carefully monitored, suggesting for example, that 'security checks on staff should be as rigorous as they are for visitors, which was not the case at Mountjoy Prison' (p. 41).

The CPT concludes its report with a list of recommendations, comments and requests for information. Included among the drug-related recommendations are the following:

- all prisoners admitted while on a methadone maintenance programme in the community to be able to continue such maintenance within prison as part of a comprehensive drug treatment programme;
- prisoners undergoing drug withdrawal to be provided with the necessary support to alleviate their suffering and not to be placed in a cell without integral sanitation;
- steps to be taken to remedy the deficiencies related to the prescription of methadone.

In its published response to the CPT report,² the Irish government explains that, while the information gathered by the CPT in relation to visits, reports and consultations of this nature is confidential, 'when requested to do so by the Government concerned, the Committee is required to simultaneously publish its report, together with the comments of the Government' (p. 5). The government's request to have both the CPT report and its own response published was made 'in the interests of openness, transparency and accountability'. Consequently, the Council of Europe published on the same day the CPT report and the response of the Irish government to the report.

(Johnny Connolly)

1. Council of Europe (2011) *Report to the government of Ireland on the visit to Ireland carried out by the European Committee for the prevention of torture and inhuman or degrading treatment or punishment (CPT)*. Strasbourg: Council of Europe. www.cpt.coe.int
2. Council of Europe (2011) *Response of the government of Ireland to the report of the European Committee for the prevention of torture and inhuman or degrading treatment or punishment (CPT) on its visit to Ireland*. Strasbourg: Council of Europe. www.cpt.coe.int

From *Drugnet Europe*

Best practice: What it is, what it isn't

Cited from article by Marica Ferri in *Drugnet Europe*, No. 73, January–March 2011

'Best practice is the best application of available evidence to current activities in the drugs field.' This is according to a group of experts tasked with developing a working definition of the concept when responding to drug use. ... According to the definition agreed, five points should be considered before applying the term best practice to an intervention, namely:

- underlying evidence should be relevant to the problems and issues affecting those involved (professionals, policymakers, drug users, their families);
- methods should be transparent, reliable and transferable and all appropriate evidence should be considered in the classification process;
- experience in implementation, adaptation and training should be systematically collected and made available;
- contextual factors should be studied by modelling different prevalence levels so as to assess the impact of an intervention on the population; and
- evidence of effectiveness and feasibility of implementation should both be considered for the broader decision-making process.

Highlighted in the discussions were the many factors to be taken into account when identifying and promoting best practice, such as how to export experiences to different contexts.

Measuring cannabis dependence in the general population

Cited from article by Danica Klempová in *Drugnet Europe*, No. 73, January–March 2011

The EMCDDA estimates that there are at least 4 million Europeans (1 % of all adults) using cannabis on a daily or almost daily basis. Most of these are males, reaching up to 5–7 % of young men (15–34 years) in some countries.

Studies show that between a third and one half of daily cannabis users fulfil dependence criteria. In order to formulate adequate policies and responses in this field, a reliable and valid measure of cannabis dependence or abuse in the population is essential. The EMCDDA is currently collaborating with national experts¹ to develop a common European measurement methodology, with results expected at the end of the year.

Pioneering work in this area began in 2002 in some countries² where psychometric scales — short instruments to assess heavier patterns of drug use — were incorporated into population surveys and tested. Results of this work were reported regularly to the EMCDDA expert group on 'Prevalence and patterns of drug use among the general population'. In recent years, the EMCDDA has actively promoted and supported the translation, adaptation and validation of such scales in additional countries, in pursuit of a common European approach.

1. Czech Republic, Germany, Ireland, Spain, France, Italy, Hungary, the Netherlands.
2. Germany, France, the Netherlands, Poland — see *Drugnet Europe* No. 63 and No. 67.

Drugnet Europe is the quarterly newsletter of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), and is available at www.emcdda.europa.eu

If you would like a hard copy of the current or future issues, please contact: Health Research Board, Knockmaun House, 42–47 Lower Mount Street, Dublin 2. Tel: 01 2345 148; Email: drugnet@hrb.ie

In brief

In the last four years 35,000 people have been killed in Mexico as drug gangs fight to gain control of the cocaine and marijuana traffic into the United States. Mexico is not alone. Other Latin American and Caribbean countries are also experiencing high levels of delinquency, violence, and corruption fuelled by illegal drugs; in some countries, democratic stability is threatened.

This issue of *In brief* reports on the work of three groups of citizens from Latin American countries, and also the US, Europe and Pakistan, who have come together to look for solutions. These citizens include former politicians and public servants, business and commercial leaders, representatives from the NGO sector, and writers and public intellectuals.

While Latin America is the major global exporter of cocaine and cannabis, the main markets for these drugs are in the US and Europe. These citizen groups are calling for an open and far-reaching public debate on how regions of the world can work together to design and implement policies that reduce both the supply and the demand for illicit drugs, rather than focusing just on the problems arising within their own jurisdictions.

In 2009 the **Latin American Commission on Drugs and Democracy**, convened by former presidents of Brazil, Colombia and Mexico, published a 41-page report *Drugs & democracy: toward a paradigm shift*. The authors point out that prohibition, comprising (1) eradicating production, (2) disrupting drug flows and (3) criminalising consumption, has not yielded the expected results. While the EU's policy of focusing on the reduction of the damages caused by drugs as a matter of public health has proved 'more humane and efficient', the authors suggest that by not emphasising the reduction of domestic consumption, the EU has failed to curb the demand for illicit drugs that stimulates their production and exportation from other parts of the world.

The Latin American Commission proposes a new paradigm based on the following three principles.

1. Treat drug users as a matter of public health – changing their status from 'drug buyers' in the illegal market to that of patients cared for in the public health system should help to undermine the economic foundations of the illegal drugs trade.
2. Reduce drug consumption – through developing information, education and prevention campaigns that can be understood and accepted by young people, who account for the largest contingent of users. The authors point to the success of information and prevention campaigns to reduce tobacco consumption, which were based on clear language and arguments consistent with the experience of those being targeted.
3. Focus repression on organised crime – target the most harmful effects of organised crime on society, and combine eradication efforts with properly financed alternative development programs adapted to local realities in terms of viable products and conditions for their competitive access to markets. www.drogasedemocracia.org/English/

In February 2011 the **Inter-American Dialogue**, supported by the UK-based **Beckley Foundation**, released a 24-page report *Rethinking US drug policy*. Endorsing the work of the Latin American Commission, this report asserts that, on the supply side, the damage caused by the production and trade in illegal drugs, combined with the increasingly well-documented collateral damage from anti-drug efforts, has now extended throughout the Americas. On the demand side, the authors comment that no existing policy option offers a solution to the problem of drug consumption. According to the authors, many advocates of harm reduction admit that while harm reduction may diminish the damage that drugs and anti-drugs measures

do to individuals and their families, to communities and nations, such interventions may also lead to higher rates of consumption.

The authors argue that because the US exerts such an enormous influence on global drug policy worldwide, changes in US laws and policies could profoundly affect the approaches of other governments and multilateral institutions. They call for the following actions.

1. Support recent Congressional initiatives to establish House and Senate commissions to review US anti-drug strategies and develop alternative approaches.
2. Join with other nations to organise an inter-governmental task force on narcotics strategy that would review and appraise global drug policies.
3. Revise outdated UN treaties that underpin the international narcotics regime.
4. Expand data collection, analysis, and research on multiple aspects of drug problems and the policies and programs designed to address them.
5. Identify and scale up successful drug programs that promise to reduce drug addiction and the health risks to addicts, increase the prospects of rehabilitation, and decrease drug-related crime. www.thedialogue.org/ / www.beckleyfoundation.org

In January 2011 the **Global Commission on Drug Policy** was established, including representatives from Latin America, the US, Europe and Pakistan. Building on the work of the Latin American Commission, its goals are to review the assumptions, effectiveness and consequences of the 'war on drugs' approach, evaluate the risks and benefits of different national responses to the drug problem, and develop actionable, evidence-based recommendations for constructive legal and drug policy reform.

Six background papers have been prepared covering the Commission's main areas of inquiry and substantive engagement:

1. The current international drug control regime.
2. A global overview of drug policies and laws.
3. The production and supply chain.
4. Criminal justice challenges.
5. Demand reduction, including prevention, harm reduction and treatment.
6. Drug trade and organised crime, and the economic and political impacts of these activities.

Chaired by ex-Brazilian president Fernando Henrique Cardoso, with George Schulz, former US Secretary of State, as Honorary Chair, the Commission includes the former presidents of Mexico and Colombia, Ernesto Zedillo and Cesar Gaviria; ex-EU foreign affairs chief Javier Solana; former Norwegian minister and international negotiator, Thorvald Stoltenberg; former President of Switzerland and Minister of Home Affairs, Ruth Dreifuss; former Secretary-General of the International Chamber of Commerce, Switzerland, Maria Cattai; former State Secretary at the German Federal Ministry of Health, Germany, Marion Caspers-Merk; Greek prime minister, George Papandreu; former Chairman of the US Federal Reserve, Paul Volcker; human rights activist and former UN Special Rapporteur on Arbitrary, Extrajudicial and Summary Executions, Pakistan, Asma Jahangir; executive director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, Michel Kazatchkine; John Whitehead, banker, civil servant and chair of the World Trade Center Memorial; Virgin chief Richard Branson; and writers Carlos Fuentes and Mario Vargas Llosa.

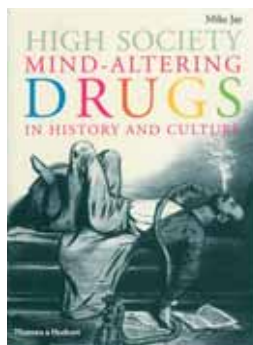
www.globalcommissionondrugs.org

(Compiled by Brigid Pike)

Recent publications

On our shelves

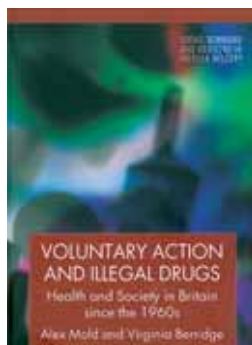
Books recently acquired by the National Documentation Centre on Drug Use



High society: mind-altering drugs in history and culture

Mike Jay

Thames & Hudson (2010); ISBN 978-0-500-25172-0



Voluntary action and illegal drugs: health and society in Britain since the 1960s

Alex Mold and Virginia Berridge

Palgrave Macmillan (2010); ISBN: 978-0-230-52140-7
www.drugsandalcohol.ie/14368

Journal articles

The following abstracts are cited from recently published articles relating to the drugs situation in Ireland.

Plant food for thought: a qualitative study of mephedrone use in Ireland

Van Hout MC and Brennan R

Drugs: education, prevention and policy 2011; Early online: 1–11
www.drugsandalcohol.ie/14541

Mephedrone is currently under legislative control in Ireland. Research on this drug remains scant, and is primarily UK based. This exploratory research aimed to present a 'consumptive snapshot' of this emerging drug in the Irish drug scene, with specific focus on mephedrone-user experiences, social situatedness of use and risk discourses.

Twenty-two in-depth interviews were undertaken with young Irish people aged 18–35 years, who had used mephedrone in the six months prior to fieldwork. Analysis of the resulting narratives identified unique mephedrone-user decision-making processes, particular drug effects and outcomes, socially contextualized mephedrone use and harm-reducing strategies grounded in prior illicit and polydrug taking careers. The research supports UK-based findings, which suggested the presence of drug displacement patterns between licit and illicit, with Irish mephedrone user preferences centralised in mephedrone availability, competitive pricing and general lack of quality illicit stimulants in the street trade. Policy makers and drug educational specialists are dealing with rapid metamorphoses and re-branding of cathinone derivatives circumventing legislation amid widespread internet availability.

Experiences with mephedrone pre-and-post legislative controls: perceptions of safety and sources of supply

McElrath K and O'Neill C

International Journal of Drug Policy 2011; 22(2):120–127
www.drugsandalcohol.ie/14625

In April 2010, mephedrone and related cathinone derivatives were banned under the UK's Misuse of Drugs Act 1971. The purpose of this paper was (1) to explore respondents' experiences with mephedrone, (2) to examine users' perceptions about the safety of mephedrone, and (3) to examine sources of mephedrone supply during the pre- and post-ban periods.

Semi-structured interviews were conducted with 23 adults who had used mephedrone during 2009–2010. Most respondents reported positive experiences with mephedrone; none reported that its once-legal status implied that it was safe to use. Very few reported buying mephedrone online or from head shops during the pre-ban period; most obtained it from friends or dealers, and mephedrone was widely available during the 10-week period following the ban.

The findings are discussed in the context of what appears to be a rapidly changing mephedrone market. We discuss the possible implications of criminalising mephedrone, including the potential displacement effects and the development of an illicit market.

Keltoi rehabilitation programme: Post-discharge outcome study

White E, Browne C, McKiernan B and Sweeney B

Drugs: education, prevention and policy 2011; Early online: 1–8
www.drugsandalcohol.ie/14766

This article presents the results of a survey of clients of Keltoi, a residential rehabilitation facility for former opiate-dependent individuals. The survey was carried out to evaluate the success of its unique programme in assisting participants to pursue a drug-free life. Between 1 and 3 years post-discharge, 53.7% (n=80) of all former Keltoi clients were interviewed with respect to abstinence, health, crime and employment measures. This was an uncontrolled cohort study.

Abstinence from all illicit drugs and alcohol in 30 days pre-interview was reported by 51.3% (n=41) of the cohort; 60.0% (n=48) reported abstinence from all illicit drugs excluding alcohol. Only 5.4% (n=5) reported injecting behaviour. Outcomes are presented with respect to crime, health and risk behaviours, social and personal functioning and employment.

The percentage of those reporting abstinence from illicit drugs was high at 60.0%, and was associated with minimal criminal activity and higher positive outcomes than non-abstinence. Exploring the association between the Keltoi approach and these encouraging results has implications for the design, delivery and evaluation of drug treatment services in Ireland, particularly in the context of the treatment and rehabilitation pillar of the National Drugs Strategy 2009–2016.

Recent publications *(continued)*

Insula and drug cravings

Garavan H

Brain Structure and Function 2010; 214(5–6):593–601

This paper reviews the role of the insula in drug craving. Evidence is presented that drug craving may be a particular instance of the anterior insula's broader role in interoception and subjective feeling states similar, for example, to thirst and hunger. An important role for the insula in craving is supported by evidence of insular activity changing with satiety and with the top-down cognitive modulation of cravings. Cognitive processes involving the insula's role in awareness of one's own behaviour may also contribute to craving insofar as the avoidance of craving might require subjective awareness of the endogenous and exogenous cues that initiate it. Finally, some consideration is given to sex differences and developmental processes in craving.

Treating alcohol-related problems within the Irish healthcare system, 1986–2007: an embedded disease model of treatment?

Cullen B

Drugs: education, prevention and policy 2011; Early online: 1–10
www.drugsandalcohol.ie/14769

This article assesses the implementation of the policy on the treatment of alcohol problems in Ireland during the period 1986–2007. At the commencement of this period, a major policy statement in relation to the treatment of alcohol within the mental health care system presaged radical change – in effect it proposed a shift from the then dominant disease model of alcoholism to one that was focused on public health principles. Towards the end of the period, a further statement made the rather sanguine claim that many of the intended changes had taken place. This article adopts a more critical approach. Using epidemiological data from annual reports on the activities

of mental health centres and also drawing from a recently conducted action-research project that focused on addiction treatment within a regional health authority, the article highlights that change has been slow and that some of the main tenets of the disease model remain in place.

Methadone and perinatal outcomes: a retrospective cohort study

Cleary B, Donnelly J, Strawbridge J, Gallagher P, Fahey T, White M and Murphy D

American Journal of Obstetrics & Gynecology 2011; 204(2): 139.e1–9

www.drugsandalcohol.ie/14818

This study examined the relationship between methadone maintenance treatment, perinatal outcomes, and neonatal abstinence syndrome. This was a retrospective cohort study of 61,030 singleton births at a large Dublin maternity hospital from 2000 to 2007.

There were 618 (1%) women on methadone at delivery. Methadone-exposed women were more likely to be younger, to book late for antenatal care, and to be smokers. Methadone exposure was associated with an increased risk of very preterm birth (less than 32 weeks gestation), being small for gestational age (below 10th percentile), admission to the neonatal unit, and diagnosis of a major congenital anomaly. There was a dose-response relationship between methadone and neonatal abstinence syndrome.

The researchers conclude that methadone exposure is associated with an increased risk of adverse perinatal outcomes, even when known adverse sociodemographic factors have been accounted for. They call for dedicated, well-resourced, multidisciplinary care for these women and their neonates to improve perinatal and long-term outcomes.

Upcoming events

(Compiled by Joan Moore – jmoore@hrb.ie)

May

10 May 2011

Drugs, alcohol and young people

Venue: Easter Road Stadium, Edinburgh

Organised by / Contact: The Big Issue

Email: susan.reid@bigissue.com

www.bigissue.com

Information: The following topics will be discussed at this conference:

- Why does alcohol affect young people differently from adults?
- Why are some of our young people being marginalised and excluded and how can we prevent it from happening?
- Would we need recovery and harm reduction if drug policy was reformed?
- How can I cope with the fall-out from the spending review?

- Where can I ask the questions that matter to me?
- What have Twitter and Facebook got to do with me?

12–13 May 2011

The public health agenda: making patient-centred care the imperative

Venue: Harrogate International Centre, North Yorkshire

Organised by / Contact: Royal College of General Practitioners / Healthcare Events

Email: matt@healthcare-events.co.uk

www.healthcare-events.co.uk/conf/booking.php?action=home&id=570

Information: This is the RCGP's 16th national conference on working with drug and alcohol users in primary care, attracting over 500 GPs, shared care workers, specialists and commissioners. In planning the conference, we are conscious of the challenges and opportunities facing primary care and our services under the coalition government; we welcome the move to place drugs and alcohol services within the public health arena, but are keen to ensure that the changes ahead do not diminish patient centred, user led treatment. The theme of the 2011 Conference addresses

Upcoming events *(continued)*

the relationship and tensions between these two areas: the imperative to maintain patient focused care as substance misuse is recognised as a public health issue.

17 May 2011
[Recovery Scotland 2011](#)

Venue: Glasgow Science Centre
Organised by / Contact: Pavilion, Association of Directors of Social Work (ADSW)

<http://pavilion-live.co.uk/recoveryscotland/2011/02/16/home>

Information: Three years on since publication of the Scottish Government's The Road to Recovery drugs strategy, Recovery Scotland 2011 provides a timely overview of the current recovery landscape in Scotland today.

The conference will identify and explore best practice, key issues and opportunities for innovation amid funding cuts. It will also examine the reconfiguration of services and an increasing awareness of the important role of service users in facilitating and sustaining the recovery journey. It will focus firstly on the personal and social recovery journey – identity, social networks and community involvement, recovery champions, recovery capital and also on the ongoing recovery journey in relation to employability, families, housing and offending.

19–21 May 2011
[8th UK/European symposium on addictive disorders](#)

Venue: Grange City Hotel, London EC3N 2BQ
Organised by / Contact: UKESAD

<http://www.ukesad.org>

Information: The UK's largest Addiction Recovery event, the UK/European Symposium on Addictive Disorders (UKESAD), will include over 60 international experts in the field of addiction who will share their knowledge with attendees in approximately 40 presentations. UKESAD is the only event in the UK and Europe which has demonstrated how to achieve long-term, sustainable recovery.

June

1 June 2011
[The role of treatment in recovery: a one-day national conference](#)

Venue: Thistle Hotel Glasgow, Glasgow, G2 3HN
Organised by / Contact: Scottish Training on Drugs and Alcohol (STRADA) Alcohol (STRADA),
Email: Debbi.Limond@glasgow.ac.uk

www.drugmisuse.isdscotland.org/news/conference_01062011.pdf

Information: This national conference developed by STRADA, a partnership of the University of Glasgow and DrugScope, will provide an unrivalled opportunity to update knowledge, hear about good practice and to meet others working in the same area. There is much discussion on the role treatment plays in recovery; while its value in the initiation and maintenance stages of recovery is acknowledged, there are debates about how treatment services should work with peer support, mutual aid and universal services to bring about long term recovery for individuals, their families and communities.

29 June 2011
[Innovations in drug and alcohol recovery](#)

Venue: Majestic Hotel, Harrogate, North Yorkshire
Organised by / Contact: Cygnet Health Care
Email: karentopping@cygnethealth.co.uk

www.cygnethealth.co.uk/about-us/events

Information: Offering tangible, practical information and experiences that delegates can take back to the workplace, this national event opens a forum for sharing and the exploration of new ideas in the field of drug & alcohol recovery.

November

3–4 November 2011
[National Drugs Conference 2011](#)

Venue: Radisson Blu Royal Hotel, Dublin 8
Organised by / Contact: Irish Needle Exchange Forum (INEF)
Email: info@inef.ie

<http://inef.ie>

Information: Details will be posted on the INEF website in due course.

Drugnet Ireland is published by:

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42–47 Lower Mount Street
Dublin 2

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